ALTERNATIVE LINK
Your Coding Company for Integrative Healthcare

45 CFR 162.940:

The Commercial Use and Cost-Benefit of ABC Codes in HIPAA Transactions and the NHII

Submitted on October 11, 2004
to the Office of the Secretary
U.S. Department of Health and Human Services

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PROJECT TEAM

Table 1. The project team included health plan, employee benefits, health industry, outcomes research, financial analysis, clinical practice management, health market and other SMEs.

Key Team Members

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Table 2: Confidential and proprietary information is protected under a prior NDA.

Alternative Link anticipates this report and future reports on cost-savings will be withheld from release under the Freedom of Information Act.

Alternative Link and CMS have a Non-Disclosure Agreement (NDA) to this end.

Alternative Link also has NDAs with ABC code set registrants that have agreed to serve as demonstration sites.

In some instances, their conditional agreement to serve as demonstration sites was based on assurances of non-disclosure of confidential and proprietary information, trade secrets and intellectual property beyond HHS personnel with an immediate need to understand the cost-benefit of ABC codes and with a legal obligation to keep such information confidential.

Alternative Link has protected all parties' confidential and proprietary information, trade secrets and intellectual property to the greatest possible degree.

However, disclosure of potentially sensitive information may have been necessary to demonstrate the cost-benefit of ABC codes.

All report content of a strategic nature must be withheld from disclosure to parties outside those within HHS who have an immediate need for this information, to ensure the greatest possible compliance with relevant NDAs and to protect demonstration sites from competitive vulnerability.

Even the de-identified information contained herein could affect the competitive landscape by making clear competitive cost structures and performance capabilities associated with strategic deployment of the ABC code set.

By reading beyond this point, HHS acknowledges the applicability of the NDA to, and the sensitivity of the information contained in, this report.

HHS agrees to limit distribution of this report and the report's organization-specific information to those within HHS who have an immediate need for this information to evaluate ABC codes as a HIPAA and NHII standard.

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ACKNOWLEDGEMENT OF DATA IMPRECISION IN INTEGRATIVE HEALTHCARE: RECOGNITION OF SCALE OF COST-BENEFIT, AND ANALYTICAL BIAS TOWARD CLARITY

Table 3. Statistics in markets addressed by this report are imprecise. For this reason, Alternative Link chose not to adjust figures for CPI, MPI, multiple reporting years, or market growth. Data sources are referenced in the Excel spreadsheet used to support this report.

Data sources are identified in the Excel spreadsheet used to support this document. This analytical tool can be provided, within a week of request.

For the sake of clarity, and because no meaningful difference in conclusions would result, Alternative Link chose not to adjust the data the Company used in cost-benefit modeling to accommodate for differences in the CPI, MPI, multiple reporting years or, in some instances, market expansion.

Also, for some calculations, Alternative Link used data that reflected a range of "healthcare" insurance categories, e.g., conventional health insurance, specialty health insurance, workers' compensation, disability, long-term care, personal injury and automotive injury. HIPAA only addresses conventional and specialty health insurance. However, a single set of metrics is essential across insurance types to achieve desired administrative simplification and NHII endpoints.

The Company believes this approach results in an understatement of the benefits of ABC codes and an appearance of a slightly less favorable cost-benefit than actually exists.

Benefits are typically determined by extending reported economic and health outcomes forward.

The compounded annual growth rate (CAGR) of complementary and alternative medicine (CAM) and a large portion of the resulting market for ABC codes has been estimated at 14.2% versus about 9% for primary care physician (PCP) services.[1]

Thus the benefits of ABC codes in integrative healthcare (IHC) are likely to be understated relative to the benefits of HIPAA code sets in the area of conventional care.

Costs relate primarily to code set training, deployment and updates. These are accounted for in today's dollars. Thus, reported costs are high relative to the underreported benefits.

The Company believes adjustments for CPI, MPI, multiple reporting years and market expansion would have complicated the cost-benefit analyses without adding value to warrant such complication. Data in the IHC markets, as well as for the cost-benefit of HIPAA standards, is generally imprecise, so Alternative Link believes minute adjustments in figures would give the false impression that the starting figures were precise. They are not. For the same reason, the Company has chosen not to conduct sensitivity analyses or present confidence ranges on costs and benefits.

The aforementioned analytical tool can be provided, within a week of request, to support these assessments.

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ACRONYMS AND ABBREVIATIONS

45 CFR 162.940	A section of the Code of Federal Regulations that permits exceptions from HIPAA standards to permit testing of proposed modifications to those standards
AAHP	American Association of Health Plans
ABC codes	A code set developed by Alternative Link
ADA	American Dental Association
AHA	American Hospital Association
AHIMA	American Health Information Management Association
AHIP	America's Health Insurance Plans
AHRQ	Agency for Healthcare Research and Quality
AMA	American Medical Association
ANSI	American National Standards Institute
ANA	American Nurses Association
APN	Advanced Practice Nurse
ASC	Accredited Standards Committee
ASCII	American Standard Code for Information Interchange
BPR	Business Process Reengineering
CAGR	Compounded Annual Growth Rate
CAHCIM	Consortium of Academic Health Centers or Integrative Medicine
CAM	Complementary and Alternative Medicine
CDC	Centers for Disease Control and Prevention
CDHP	Consumer-Driven or Consumer-Directed Health Plan
CFR	Code of Federal Regulations
CAHCIM	Consortium of Academic Health Centers for Integrative Medicine
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DCC	Dental Content Committee of the American Dental Association
DDS	Doctor of Dental Surgery
DDSc	Doctor of Dental Science
DMD	Doctor of Medical Dentistry
DO	Doctor of Osteopathic Medicine
DSMO	Designated Standards Maintenance Organization
EDI	Electronic Data Interchange
GDP	Gross Domestic Product
HCFA	Health Care Financing Administration
HCIT	Healthcare or Health Care Information Technology
	HCPCS Healthcare Common Procedure Coding System
HCPCS Level I or HCPCS I	Healthcare Common Procedure Coding System - Level One
HCPCS Level II or HCPCS II	Healthcare Common Procedure Coding System - Level Two
HEDIS	Health Plan Employer Data and Information Set
HHS	United States Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HL7	Health Level Seven

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HMO	Health maintenance organization
ICD-9	International Classification of Diseases, 9th Revision
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICD-10	International Classification of Diseases, 10th Revision
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification
IHC	Integrative Healthcare (i.e., care that includes allied and public health, nursing, CAM, culturally competent and progressive allopathic approaches to care)
IHCP	IHC Practitioner
IT	Information Technology
JIT	Just in Time (i.e., delivered upon need)
MD	Medical Doctor
NACNS	National Association of Clinical Nurse Specialists
NCHS	National Center for Health Statistics
NCPDP	National Council for Prescription Drug Programs
NCVHS	National Committee on Vital and Health Statistics
NEC	Not Elsewhere Classified
NOC	Not Otherwise Classified
NCCAM	National Center for Complementary and Alternative Medicine of the National Institutes of Health
NHI	National Health Information
NHII	National Health Information Infrastructure
NLM	National Library of Medicine
NOS	Not Otherwise Specified
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claim Committee
OCR	Optical Character Recognition
OPM	Office of Personnel Management
OMH	Office of Minority Health
PCP	Primary Care Practitioner
PPO	Preferred Provider Organization
RBRVS	Resource Based Relative Value System/Scale (Medicare/Medicaid methodology)
RVU	Relative Value Units ("Relative Values for Physicians" methodology)
SBU	Strategic Business Unit
SIG	Special Interest Group
SME	Subject Matter Expert
SNIP	Strategic National Implementation Process
SSO	Standard-Setting Organization
UCR	Usual, Customary and Reasonable
UMLS	Unified Medical Language System
VA	Department of Veterans Affairs

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VISTA	Veterans Health Information Systems and Technology Architecture
WEDI	Workgroup for Electronic Data Interchange
WHCCAMP	White House Commission on Complementary and Alternative Medicine Policy
WHO	World Health Organization
XML	Extensible Markup Language
X12	ANSI Standard for Inter-Industry EDI of Business Transactions

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EXECUTIVE SUMMARY

Purpose of the Report: The Cost-Benefit of ABC Codes Justifies Inclusion in HCPCS

This report supports designation of ABC codes as Level IV of the Healthcare Common Procedure Coding System (HCPCS) under the Health Insurance Portability and Accountability Act (HIPAA) and supports $51 billion in healthcare savings each year.[2]

Alternative Link[3] requests the Secretary of the U.S. Department of Health and Human Services (HHS) announce this designation and guide code set implementation as a national standard through the Designated Standards Maintenance Organizations (DSMOs), the National Committee on Vital and Health Statistics (NCVHS) and the Centers for Medicare & Medicaid Services (CMS).[4]

Alternative Link also seeks an extension of availability of ABC codes under 45 CFR 162.940 through October 16, 2007, or until the code set becomes mandatory under HIPAA. This will support continued commercial use of the codes in HIPAA transactions and other applications by current code set users. It will also give covered entities, trading partners and business associates that did not register to use the codes under HIPAA the ability to begin to implement the ABC codes as part of the HIPAA standard.

Finally, Alternative Link seeks an HHS directive to all HCPCS coding authorities to avoid terminology and code duplication and to address ABC codes in an objective, timely and transparent HCPCS code harmonization process.

Rationale for Report: ABC Codes Are Essential to Proper Maintenance of HCPCS

This recommendation is supported by

1. ***quantitative evidence*** of the cost-benefit of ABC codes in HIPAA transactions, supporting administrative simplification, and generating greater business and industry efficiencies;
2. ***qualitative evidence*** of the value of ABC codes to individual and public health, the U.S. healthcare system, and the nation's socioeconomic development; and
3. ***a legal analysis*** that establishes the addition of ABC codes to HCPCS as a HIPAA code set maintenance step rather than a modification step.

Alternative Link's legal and regulatory advisors[5] have determined that 45 CFR 162.940 was not conceptualized for, and has not been applied to, HIPAA code set maintenance issues.

Under a legal analysis submitted to the Office of the Secretary, they establish that HCPCS maintenance steps, such as adding ABC codes as a Level IV code set, may be taken without testing and reporting under 45 CFR 162.940 and without a Notice of Proposed Rule Making (NPRM).

Recognizing ABC codes as relevant to maintenance rather than modification of the HIPAA code set standards, Alternative Link offers this cost-benefit evaluation under 45 CFR 162.940 to reinforce the rationale and urgency associated with establishing ABC codes as HCPCS Level IV codes.

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While written for the HHS Secretary, the report may be important to those within HHS responsible for the HIPAA transactions and code sets, healthcare informatics and the National Health Information Infrastructure (NHII).

Contents of the Report: ABC Codes Have a Favorable Cost-Benefit in Commercial Use

In support of this recommendation, the report presents cost-benefit and other data on the use of ABC codes in

1. HIPAA transactions and related administrative simplification;
2. improving individual and public health;
3. improving business and industry efficiencies; and
4. supporting the nation's socioeconomic development.

The report focuses on the ability of ABC codes

1. to provide a favorable cost-benefit in relation to other available solutions, when used in conjunctions with existing HCPCS codes;
2. to comply with the ten guiding principles for HIPAA standards;[6] and
3. to meet the healthcare financing, administration and delivery needs of health industry stakeholders up and down the healthcare vertical and across the continuum of care.

Report Organization, Methodology and Findings: Following Cost-Benefit Precedents Established by CMS and Others, Alternative Link Demonstrates a $51 Billion Net Benefit From ABC Codes Within One Year of Deployment

Alternative Link organized this report to enable an individual unfamiliar with ABC codes to conclude that

1. the codes should be named a Level IV subset of HCPCS and a HIPAA and NHII standard,
2. an extension of availability of the codes under 45 CFR 162.940 would support Congressional intent under HIPAA and is essential to the continued commercial use of the codes, and
3. immediate inclusion of the codes in HHS code harmonization initiatives will best serve the U.S. healthcare system and its constituents.

The report opens with the historic background and regulatory context for the cost-benefit evaluation of ABC codes. It illustrates the variability in health insurance mandates across states, diagnoses, technologies and caregivers. It makes clear the need to capture impartial data to help Americans gain access to cost-effective and evidence-based care and caregivers—so access is not unduly influenced by any particular special interest group or groups (SIGs). It calls attention to advanced practice nurses (APNs) and the contributions they could make to wellness, primary care and the conditions of the medically underserved if the HIPAA and NHII standards supported that. It reviews results of an HHS study on growing consumer demand for complementary and alternative medicine (CAM). It considers the importance of data collection and analysis in determining the causes of, and finding solutions to, health disparities—especially among racial and ethnic minorities.

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The report then reviews the code set's design and functionality, addresses the types of practices and practitioners it serves, and illustrates in a case study of one of the nation's largest health plans how the codes work independently of, and in conjunction with, other critical data elements such as practitioner identifiers, relative values, legal scope of practice information and practitioner training standards.

Table 4. Caps on annual chiropractic visits and expenditures are evidence of the need for ABC codes.

Many health plans limit chiropractic benefits, e.g., they may allow only $500 or 10 visits per year rather than permit chiropractic care in all instances in which it is cost-effective and evidence-based. Health plans cap annual visits or expenditures for chiropractic care because they lack complete, accurate and precise codes for these interventions and have no other way to forecast and control access to, or the costs associated with, this category of care.

The next section recaps the steps that were taken between 1996 and 2003 to secure a timely, objective and transparent evaluation of the codes as a HIPAA standard. The section addresses the DSMOs and the NCVHS and ends by noting additional high level attention the code set has received.

The section that follows clarifies why Alternative Link sought an HHS exception to allow the health industry to use and evaluate ABC codes as a proposed modification to the HIPAA standards beyond the HIPAA transaction and code set compliance date of October 16, 2003. It addressed differences between test requirements established in the HHS exception authorization letter, those established by the CMS Office of HIPAA standards guidelines, and precedents for cost-benefit analyses of HIPAA standards set by CMS, WEDI, RAND and others. The section concludes with 1) a review of the costs and benefits that had been noted prior to the authorization of the cost-benefit evaluation under 45 CRF 162.940, and 2) a description of the methodology that Alternative Link used to gather cost-benefit data that supplements those earlier reports and helps HHS consider the value of naming ABC codes a HIPAA standard.

The report offers evidence of the cost-benefit of ABC codes both within and beyond HIPAA. First, the report summarizes qualitative and quantitative industry data that supports the cost-benefit of ABC codes in HIPAA transactions. The gap in the HIPAA code sets is noted. The report calls attention to the fact that HIPAA codes focus on the practices of less than 15.3% of the health practitioners in the U.S. healthcare system, leaving some 84.7% of practitioners without adequate codes to reflect their practices.

The challenge faced by health plans as a result of the obsolescence of HCPCS III (local codes) is also addressed, and a key WEDI observation and suggestion are reviewed:

> "This may disproportionately affect the readiness of certain provider types who are less well-supported by current national code structures…a process to identify, get consensus on, and expedite the introduction of additions to the code standards is needed…emerging fields such as alternative health care, genetic therapy, and other non-traditional methods of treatment must also be assigned to a standards body for regulation."

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The report then focuses on the ability of ABC codes to impartially fill gaps in the HIPAA standards—including those left by retirement of HCPCS III local codes—and work seamlessly with the original HIPAA code sets.

Table 5. Medicaid programs need ABC codes to deliver functionality of retiring HCPCS III codes.

Quote:

"…I have stressed the importance of endorsing your organization and your efforts to have the ABC code set approved as part of a HIPAA compliant code set…

If Alternative Link fails to succeed in getting approval for ABC codes to become a HIPAA compliant code set, our division (de-identified) may have to consider regulation change to eliminate covered services."

- Medicaid Administrator in an email to Alternative Link, spring 2004

The report illustrates the use of ABC codes in a CMS-1500 form and compares the precision of CPT, HCPCS II and ABC codes in relation to IHC. It describes the use of practitioner identifiers as code modifiers. It emphasizes the systematic development of ABC codes to support emerging healthcare markets such as obesity management, end of life care, genetic profiling and counseling, abstinence and sex education, and culturally competent care. Finally, it presents an example of how use of a precise ABC code for weight management counseling in a group setting would deliver value to practitioners, provider organizations, credentialing bodies, healthcare clearinghouses, health plans and health policymakers.

At this point, the report makes note of a CMS conclusion in its "Impact Analysis" for HIPAA standards:

> The costs of implementing the standards…are primarily one-time or short-term costs related to conversion. These costs include system conversion/upgrade costs, start-up costs of automation, training costs, and costs associated with implementation problems.
>
> The benefits…include reduction in manual data entry, elimination of postal service delays, the elimination of costs associated with the use of paper forms, and the enhanced ability of participants in the market to interact with each other.

The report confirms these conclusions apply to the cost-benefits of ABC codes. In comparison to CMS reports of a net benefit of $1.6 billion for health plans and $1.5 billion for providers for all of the HIPAA standards,[7] Alternative Link reports the following costs and benefits associated with deployment of ABC codes:

Deployment and maintenance of ABC codes will cost the nation $1.1 billion in year one and $225 million annually thereafter:

- Initial data acquisition will cost the industry $117.2 million.
- Initial data deployment will cost the industry $32.4 million.
- Initial training will cost $917.7 million.
- Annual training will cost $91.8 million.
- Annual updates and maintenance will cost the industry $133.4 million.

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Deployment of ABC codes will generate U.S. healthcare system savings of $52 billion.

- Expansion of EDI will save more than $17.3 billion. Within this category of savings, elimination of unnecessary communications will save more than $7.8 billion.
- Administrative efficiencies in areas other than EDI will save more than $3.1 billion.
- Use of cost-effective IHC will save more than $15.0 billion.
- Improved relative values will save more than $7.7 billion.
- Practitioner identifiers and elimination of unnecessary claim forms will save $478.6 million.
- Reduced MD supervision and administrative fees will save $8.6 billion.

The report notes that, prior to the development of ABC codes, a health practitioner trade association was the primary coding authority for health interventions, whether delivered by MDs or IHCPs. Many of the codes this organization developed for IHCPs were not sufficiently granular to support direct billing by IHCPs. IHCPs could bill directly if they had access to ABC codes

The report considers additional benefits that could be generated from increased market participant interaction. It then reviews the significant costs likely to result from the industry developing and deploying *next generation* functionality that could be activated with ABC codes (e.g., "real time" outcomes research and health policy development from claims data). Alternative Link views these extra investments as part of 1) the cost of doing HIPAA compliant business in a new health market, 2) the cost of gaining EDI capabilities across health markets, and 3) the cost of continuous process improvement.

The Company points to a demonstration site report to reinforce that implementation challenges are likely to be a result of business process design flaws and that the attention given to business process reengineering is likely to create even greater savings.

Following a line of reasoning made in CMS's "Impact Analysis" and the RAND cost-benefit study of ICD-10, Alternative Link notes these costs should not be attributed directly to ABC codes in the cost-benefit analysis but that related benefits would not be possible without ABC codes and are, therefore, legitimately accrued to, and understood as part of the benefit of, the code set.

The report then focuses on data collected under 45 CFR 162.940 to confirm

- The validity of theoretical models of the favorable cost-benefits offered by ABC codes if deployed nationally;
- the scale of savings already evident from the code set deployment experiences of demonstration sites, and
- the legitimacy of favorable cost-benefit expectations among registrants.

The vast majority of registrants anticipated more benefits than costs would accrue to public health, the U.S. healthcare system, registrant organizations, registrants' professions, registrants' careers and jobs; and consumers.

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Registrants included public and private health plans (e.g., California Medicaid, New York Medicaid, Aetna, Kaiser, Department of Veterans Affairs, Blue Cross/Blue Shield (BCBS) Plans, Motion Picture and Television Fund, Jungle Gyms International), healthcare information technology companies (e.g., EDS, 3M, McKesson, WebMD), academic institutions (e.g., Harvard, Duke, University of California), practitioner associations (American Nurses Association, American Association of Oriental Medicine, Midwives Alliance of North America) and others.

The report then reviews each of the ten guiding principles of HIPAA standards and provides additional qualitative and quantitative evidence to illustrate that the codes support these principles.

Finally, the report addresses the authority granted to the Secretary under 45 CFR 162.940 and makes specific recommendations about how to harvest the benefits of ABC codes to better support

- Congressional intent under HIPAA,
- Presidential intent in the April 2004 NHII Executive Order,
- HHS strategic objectives vis-à-vis individual and public health,
- business and industry efficiencies and
- socioeconomic development.

A complete legal analysis of 45 CFR 162.940 and the relevance of ABC codes to HCPCS code set maintenance was submitted to the Office of the Secretary under separate cover.

The exhibits and endnotes illustrate or substantiate points made in the report and reinforce Alternative Link's primary research findings under 45 CFR 162.940 with independent sources, wherever possible.

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HISTORIC BACKGROUND AND REGULATORY CONTEXT FOR THE REPORT

Alternative Link Developed Codes and Data Elements Essential to U.S. Healthcare

Alternative Link was founded in 1996, the same year that HIPAA was enacted.

HIPAA was intended, in part, to reduce the costs and administrative burdens of healthcare through the use of standardized EDI. It required health plans, clearinghouses, and providers to standardize electronic transactions and to use standard code sets in a confidential and secure environment within two years following the publication of the Final Rule (August 17, 2000) or by October 16, 2003, if covered entities applied for extensions under the Administrative Simplification Compliance Act.[8]

Alternative Link and its strategic allies committed to develop not only gap-filling codes for HIPAA and the NHII, but also four other missing elements of the NHII. While these elements are not being proposed as part of the HIPAA standard, they are important to address in this report because they can work in conjunction with ABC and HCPCS codes to ensure a greater number of Americans gain access to the right care in the right place at the right time, at a rational cost.

The importance of ABC codes to U.S. healthcare is made clear in Exhibits A through E. Exhibit A illustrates the variability in health insurance mandates across states, diagnoses, technologies and caregivers. Exhibit B makes clear the need to capture impartial data to help Americans gain access to cost-effective and evidence-based care and caregivers—so access is not unduly influenced by any particular special interest group or groups (SIGs). Exhibit C calls attention to advanced practice nurses (APNs) and the contributions they could make to wellness, primary care and the conditions of the medically underserved if the HIPAA and NHII standards supported that. Exhibit D provides results of an HHS study on growing consumer demand for CAM. Exhibit E emphasizes the importance of broad-based data collection and analysis in determining the causes of, and finding solutions to, health disparities—especially among racial and ethnic minorities.

Following Congressional intent under HIPAA, Alternative Link and its allies developed ABC codes and practitioner identifiers that could be used as code modifiers. These data elements supported development of relative value units, legal practice guidelines and training standards applicable on a per intervention, per practitioner and per state basis.

ABC codes fill gaps in the medical and dental HCPCS codes and already represent the practices of more than 3 million IHCPs and more than 1.6 billion outpatient IHCP encounters.[9] They will soon represent the practices of an estimated 6 million IHCPs. (In contrast, CPT[10] and CDT[11] codes—the medical and dental coding standards— represent the practices of an estimated 853,187 allopathic physicians and 92,460 dentists (referred to as MDs[12] from this point forward), an estimated 1.2 billion annual physician office visits and a fraction as many dental office visits.)[13] [14]

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Table 6. Allopathic medicine is analogous to conventional or Western medicine.

Allopathy
That system of medical practice which aims to combat disease by the use of remedies which produce effects different from those produced by the special disease treated; a term invented by Hahnemann to designate the ordinary practice, as opposed to homeopathy.

Practitioner identifiers help establish legal scope of practice on a coded line-specific basis on insurance claim forms. These ABC code modifiers are useful in contracting, credentialing, clinical practice design and other applications. They are similar in function to provider taxonomy codes but the ABC codes' practitioner identifiers map to state statutes, administrative regulations and case law to enhance the functionality of the industry's database querying tools.

Relative value units or RVUs establish the financial worth of healthcare interventions based on a variety of factors associated with delivered care, including time, skill, risk to patient, risk to practitioner and severity of the health condition.

Legal practice guidelines establish the legality of delivered care reflected by ABC codes, based on scope of practice laws found in state statutes, administrative regulations and case law.

Training standards establish academic, licensing, credentialing and continuing education requirements.

Similar in structure to HCPCS codes, ABC codes were designed from the ground up to meet HIPAA requirements and support electronic commerce for the majority of the nation's health practitioners. However, used in conjunction with practitioner identifiers, RVUs, legal practice guidelines and training standards, ABC codes offer unprecedented value not only in HIPAA administrative simplification initiatives, but also within the NHII—value that cannot be derived from the prior code sets alone. ABC codes can immediately fulfill the nation's need to completely, accurately and precisely document the financing, administration and delivery of all approaches to care to support best practices.[15]

An illustration of the use of ABC codes in claims processing is included as Exhibit F.

A cross section of a database with ABC codes, legal logic and RVUs (that would result from a query based on a practitioner identifier/modifier, to assess legal scope of practice) is presented in the case study below.

ABC Codes Reflect IHC Interventions

ABC codes reflect a broad range of healthcare disciplines beyond conventional medicine delivered by MDs. The codes are being expanded into important fields such as palliative care, obesity and weight management, and generic profiling and counseling.

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Table 7. ABC codes reflect IHC practices.

• Acupuncture	• Holistic Nursing	• Naturopathic Medicine
• Ayurvedic Medicine	• Homeopathic Medicine	• Oriental Medicine
• Bodywork	• Indigenous Medicine	• Osteopathic Medicine
• Botanical Medicine	• Massage Therapy	• Physical Medicine
• Chiropractic	• Mental Healthcare	• Reflexology
• Clinical Nutrition	• Midwifery	• Somatic Practices
• Conventional Nursing	• Minority Healthcare	• Spiritual Care
• Holistic Medicine	• Naprapathy	

ABC Codes Are Used Primarily by IHCPs

ABC codes reflect the practices of a broad range of caregivers not adequately served by 1) the HIPAA code sets and 2) related code development and maintenance processes.

Among conventional MDs, holistic caregivers—such as members of the American Holistic Medical Association[16]—will find the code set improves documentation relative to the IHC they deliver.

IHCPs will find the code set extends the benefits of HIPAA to them and enables their most cost-effective practices to gain appropriate recognition and support.

Table 8. The 2005 ABC code set supports IHCPs.

• Advanced Nurse Practitioners	• Doctors of Naprapathy	• Culturally Competent Caregivers
• Certified Nurse Midwives	• Doctors of Oriental Medicine	• Naturopathic Doctors
• Christian Science Nurses	• Doctors of Osteopathy	• Occupational Therapists
• Christian Science Practitioners	• Holistic Dentists	• Physical Therapists
• Clinical Nurse Specialists	• Holistic Medical Doctors	• Physician Assistants
• Direct-Entry Midwives	• Licensed Vocational Nurses	• Reflexologists
• Doctors of Chiropractic	• Massage Therapists	• Registered Dieticians
• Doctors of Homeopathy	• Mental Health Professionals	• Registered Nurses

A Case Study Illustrates the Cost-Benefits Associated With ABC Codes

A case study illustrates the importance of ABC codes to HIPAA, the NHII, the U.S. Healthcare System, the Nation's Economy and the American People

A national health plan's corporate strategy made certain the addition of new practitioner types that were viewed as essential to meeting the healthcare needs of consumers, employers and the government.

The health plan's Chairman and CEO noted that the company was "transforming itself into a consumer-centric company, focused on bringing together the best products, information and services to create a positive experience for consumers."

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He anticipated the company would be "a leader, cooperating with others to build a stronger, more effective healthcare system."

He planned to "continue to take the lead on addressing many of the challenges facing our industry and the nation."

Following this strategy, the health plan's medical policy team realized it needed to create an optimal corporate health information infrastructure (HII) to support the design and launch of two new benefit plans.

These health plans reflected critical socio-demographic trends and included
1. end of life care (palliative care) for aging baby boomers and their parents; and
2. weight management to reduce to human suffering and medical costs associated with the obesity epidemic, especially among medically underserved populations (such as minorities).

IHC practices were highly relevant to these benefit plans. The end of life product could elicit insurance claims from clinical nurse specialists, social workers, pastoral counselors and others. The company noted that it needed to support—among other things—cost-effective nursing services and nursing professionals, in which each professional specialty has its own training, certification and licensing requirements.

The weight management product could elicit claims from nutritionists, registered dieticians, herbalists, personal trainers, naturopaths, psychologists, sports doctors who recommended nutritional supplements, hypno-therapists and others. The company needed to address the care delivered by IHCPs, who had tremendous variability in legal scope of practice based on statutes, administrative regulations and case law.

An immediate challenge that faced the health plan was that HCPCS codes were too imprecise to support an assessment of the legality, medical necessity and economic value of care delivered by these IHC practitioners.

The HCPCS codes also offered insufficient granularity in reflecting IHC to support benefit plan design, managed care and provider contracting, utilization and clinical practice management, claims management, outcomes research and actuarial analyses.

ABC codes offered three potential solutions to this health plan's challenge. (These solutions are being deployed at the health plan in the order described.)

First, a flagged CPT or HCPCS code could be mapped to the nearest possible ABC code or codes and, if something close to a 1:1 relationship existed, the legal, clinical and relative value data associated with ABC codes could be assigned to the CPT code.

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Direct 1:1 mapping from a HCPCS code to an ABC code was only necessary for HCPCS codes that reflected care that could be illegal, clinically inappropriate or economically unjustified for an IHCP in one or more regions of the U.S. In such instances, the practitioner identifier used as a code modifier on the ABC code would allow for a practitioner-specific determination of legality, clinical efficacy and cost-effectiveness.

Second, a mechanism could be established to give a practitioner, provider organization, clearinghouse or health plan a dropdown menu of all ABC codes that added precision to a given non-granular HCPCS code.

Since ABC codes were developed to fill gaps and add precision to HCPCS codes, this was applicable to more than 92% HCPCS codes related to IHC.

Third, a health plan and all its trading partners and business associates could be trained to use ABC codes side by side with HCPCS codes.

ABC codes, practitioner identifiers and other data housed in Alternative Link's HealthIntel Database (which is maintained in a SQL Version 7.0/2000 format) were essential to addressing the health plan's needs. (Only the ABC codes and practitioner identifiers are proposed as part of the HIPAA standard code sets.)

In addition to the ABC codes and practitioner identifiers, the data elements that were essential to the health plan's research, management and commerce processes included 1) hierarchic descriptions of care, 2) standardized and expanded definitions of care (based on clinical terminology) that could be housed electronically to avoid the need for claims attachments, 3) relative values units, 4) statutes, 5) administrative regulations, 6) case law, 7) training standards, 8) determinations of legality of care, 9) determinations of clinical necessity of care, and 10) determinations of cost-effectiveness of care.

Alternative Link's HealthIntel Database addressed data elements 1 through 8.

To secure clinical efficacy (item 9) and cost-effectiveness information (item 10), Alternative Link identified third parties that compiled those data elements.

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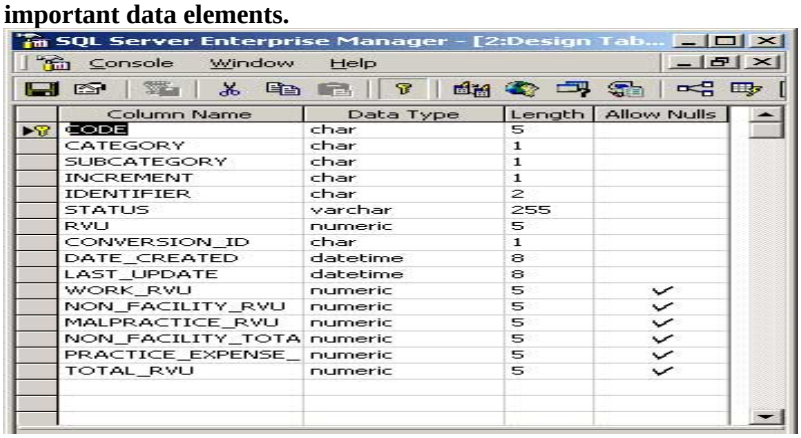
It included (but was not limited to) the following fields:

Table 9: The HealthIntel Database houses ABC codes and other important data elements.



Column Name	Data Type	Length	Allow Nulls
CODE	char	5	
CATEGORY	char	1	
SUBCATEGORY	char	1	
INCREMENT	char	1	
IDENTIFIER	char	2	
STATUS	varchar	255	
RVU	numeric	5	
CONVERSION_ID	char	1	
DATE_CREATED	datetime	8	
LAST_UPDATE	datetime	8	
WORK_RVU	numeric	5	✓
NON_FACILITY_RVU	numeric	5	✓
MALPRACTICE_RVU	numeric	5	✓
NON_FACILITY_TOTA	numeric	5	✓
PRACTICE_EXPENSE_	numeric	5	✓
TOTAL_RVU	numeric	5	✓

To support automated claims adjudication, credentialing and provider contracting for the end of life and obesity management products, the national health plan needed a comparison of legal scopes of practice for IHCPs.

The tables below were illustrative queries or "cross sections" of the HealthIntel Database focused on naturopaths and clinical nurse specialists, respectively.

The examples were taken from the State of Washington.

Table 10: The HealthIntel Database elements support assessments of the legality of care on a per intervention, per practitioner and per state basis.

ABC Code	Practitioner ID / Modifier	Legal?	Relative Value Unit	ABC Code Description	Expanded Definition
NAAHK	1E	Yes	5.2	Pressure ulcer prevention, Common nursing interventions, Nursing interventions, Nursing	Providing a patient with assistance and/or education to prevent him or her getting a pressure ulcer(s).
NAAGN	1E	Yes	23.3	Pain management and/or control initial 60 minutes, Common nursing interventions, Nursing interventions, Nursing	Managing and/or controlling a patient's pain levels. For additional time, use NAAGO. Service is billed in 60-minute increments.
ADXAN	1E	No	0	Schedule II controlled substance prescription(s) no charge, Recommendation and/or prescription services with or without ICD diagnosis, General service and referral codes, Clinical practice management	Prescribing Schedule II controlled substances. Service is billed as a no-charge item.
BFDAE	1E	Yes	4.0	Nutrition management individual each 15 minutes, Nutrition management, Nutrition services, Multiple specialties	Supporting a client in managing his or her balanced dietary food intake. Service is billed in 15-minute increments.

One intervention, writing a prescription (ABC code ADXAN), was noted as illegal for naturopaths in Washington. In contrast, the clinical nurse specialists had this prescriptive authority in Washington.

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Table 11. Legal scope of practice varies by intervention, practitioner type and state.

ABC Code	Practitioner ID / Modifier	Legal?	Relative Value Unit	ABC Code Description	Expanded Definition
NAAHK	1F	Yes	5.2	Pressure ulcer prevention, Common nursing interventions, Nursing interventions, Nursing	Providing a patient with assistance and/or education to prevent him or her getting a pressure ulcer(s).
NAAGN	1F	Yes	23.3	Pain management and/or control initial 60 minutes, Common nursing interventions, Nursing interventions, Nursing	Managing and/or controlling a patient's pain levels. For additional time, use NAAGO. Service is billed in 60-minute increments.
ADXAN	1F	Yes	0	Schedule II controlled substance prescription(s) no charge, Recommendation and/or prescription services with or without ICD diagnosis, General service and referral codes, Clinical practice management	Prescribing Schedule II controlled substances. Service is billed as a no-charge item.
BFBAE	1F	Yes	4.0	Nutrition management individual each 15 minutes, Nutrition management, Nutrition services, Multiple specialties	Supporting a client in managing his or her balanced dietary food intake. Service is billed in 15-minute increments.

To be paid by the health plan, the practitioners needed proper credentials and an established managed care contract. The HealthIntel Database helped the health plan understand the training and licensing the practitioners needed to have to legally provide each type of care.

Table 12. The HealthIntel Database includes practitioner training and licensing standards.

ABC Code	Naturopathic Doctor
BFBAE Nutrition management	A naturopathic physician in Washington must 1) complete a doctoral program in naturopathy approved by the Washington State Department of Health, 2) pass an approved examination and 3) complete seven hours of AIDS education.

ABC Code	Clinical Nurse Specialist
NAAGN Pain management and control	An advanced registered nurse practitioner in Washington must 1) complete an advanced registered nurse practitioner training program, 2) meet criteria established by the Washington State Nursing Care Quality Assurance Commission and 3) be certified by an approved national certifying body.

The HealthIntel Database was regularly updated as care descriptions, practitioner types, relative values, statutes, administrative regulations, case law, training requirements and licensing requirements changed, so the health plan would always have reliable information.

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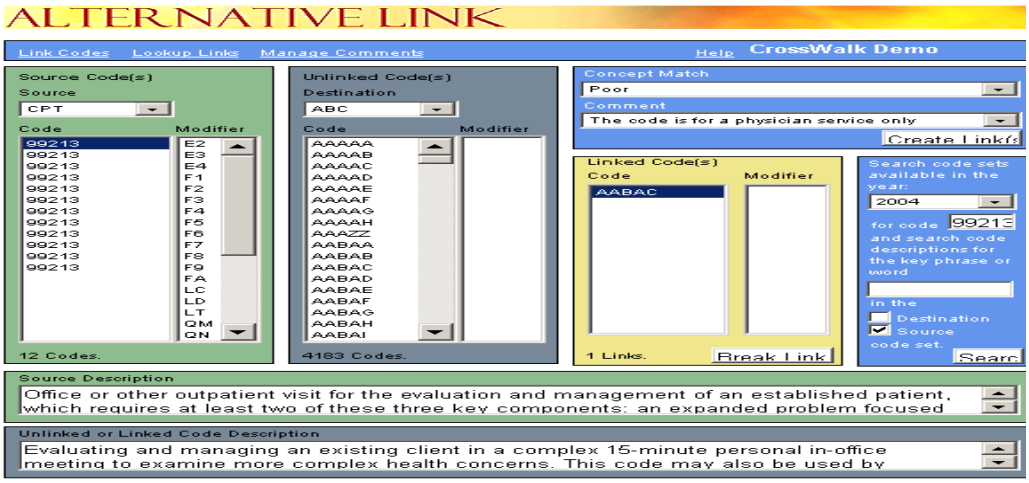
Focusing on automating claims adjudication, the health plan asked Alternative Link to address some troublesome HCPCS codes in the State of Utah. CPT code 99213 mapped to ABC code AABAC in a 1:1 relationship as illustrated.

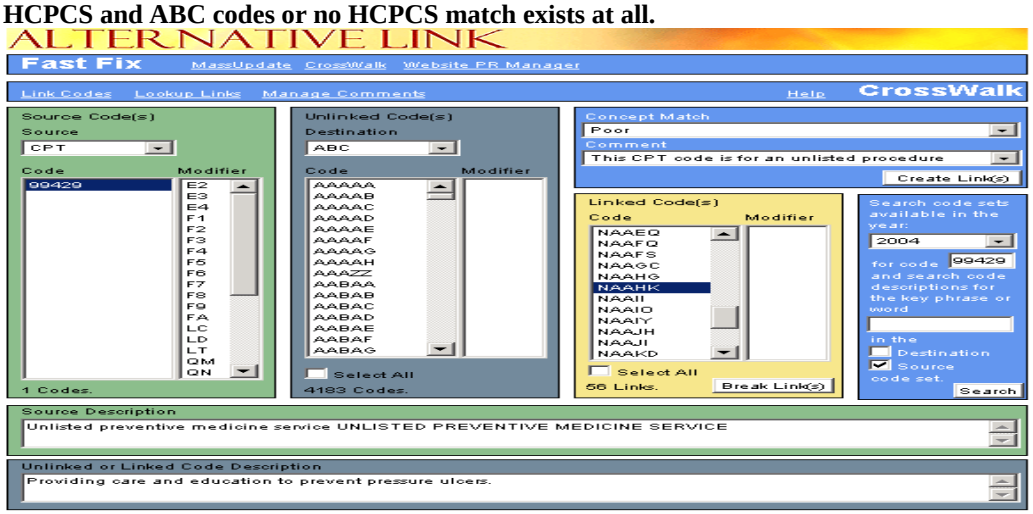
Table 13. The relationship between HCPCS and ABC codes is 1:1 less than 8% of the time.



In this case, AABAC was legally appropriate for a naturopath in Utah (Reference: UT ST s 58-71-102), so CPT code 99213, when billed by this practitioner type, was also legal.

In contrast, CPT code 99429 mapped (crosswalked) to more than 50 ABC codes, as illustrated.

Table 14. More than 92% of the time, either a one-to-many relationship exists between HCPCS and ABC codes or no HCPCS match exists at all.



In this case, NAAHK (for care and education for prevention of pressure ulcers) was legally appropriate for a naturopath in Utah *(Reference: UT ST s 58-71-102*). However, that information could not be derived on the basis of the CPT code alone. It could only be derived through use of ABC code and the practitioner identifier for a naturopath.

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The variability in legal scope of practice was illustrated by the following table for two other codes. Each 2-character modifier reflected a different practitioner type. The "Y" was a legal logic indicator, with "Y" symbolizing "Yes, this is within legal scope of practice in this state" (Washington) and a blank space indicating "No, this is not within legal scope of practice in this state."

Table 15. The software application used to build the ABC code set houses data that supports automated assessments of the legality of a specific intervention across practitioner types and states.

ABC Code	Description	RVUs	1A	1B	1C	1D	1E	1F	1G	1H	1J	1K	1L	1M	1N
BFBAE	Nutrition management individual each 15 minutes, Nutrition management, Nutrition services, Multiple specialties	4	Y		Y	Y	Y	Y	Y	Y		Y	Y	Y	Y
NAAGN	Pain management and/or control initial 60 minutes, Common nursing interventions, Nursing interventions, Nursing	23.3				Y	Y	Y	Y	Y		Y	Y	Y	Y

1A = Chiropractor 1C = Acupuncturist 1E = Naturopathic Doctor
1F = Clinical Nurse Specialist 1L = Doctor of Osteopathy 1M = Medical Doctor

Training and legality determinations were derived from statutes, administrative regulations and state law, as well as training, licensing and credentialing authorities.

Table 16. Once a practitioner type is identified, the data housed in the HealthIntel Database can be used to reveal why that type of practitioner is or is not allowed to deliver a specific healthcare intervention in a particular state.

ABC Code	Practitioner Identifier	Legality in WA	Citation
BFBAE	1E	Yes	According to Washington statute, naturopathic medicine or naturopathy is "the practice by naturopaths of the art and science of the diagnosis, prevention, and treatment of disorders of the body by stimulation or support, or both, of the natural processes of the human body. A naturopath is responsible and accountable to the consumer for the quality of naturopathic care rendered. The practice of naturopathy includes manual manipulation (mechanotherapy), the prescription, administration, dispensing, and use, except for the treatment of malignancies or neoplastic disease, of nutrition and food science, physical modalities, homeopathy, certain medicines of mineral, animal, and botanical origin, hygiene and immunization, common diagnostic procedures, and suggestion."

Web services were designed to help the health plan understand how to auto-adjudicate claims from such practitioners and to help practitioners submit legally, clinically and economically justified CMS-1500 forms or 837P transactions.

The practitioner and health plan processes are illustrated below. The corresponding narrative reflects the design of the web services from the perspective of an end user.

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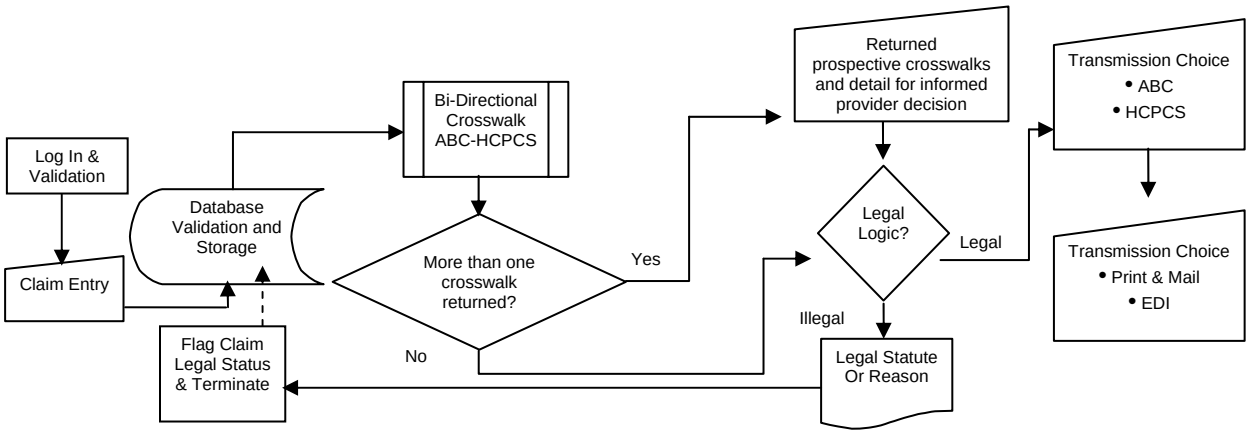
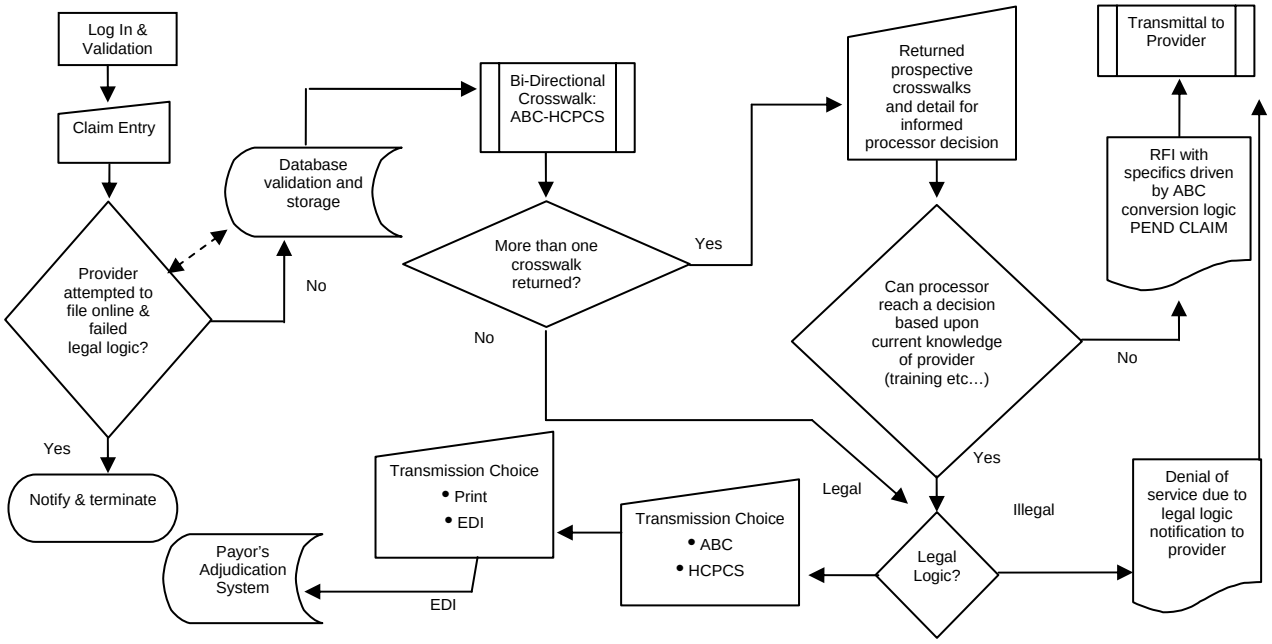
Figure 1. The design of the web services allows a practitioner with a minimal understanding of ABC codes to data enter a generic HCPCS code and select a more precise ABC code from a dropdown menu.



Source: ©2004 ClaimEDIx. Confidential and proprietary.

Figure 2. Health plans can use the web services to support automated claims adjudication.



Source: ©2004 ClaimEDIx. Confidential and proprietary.

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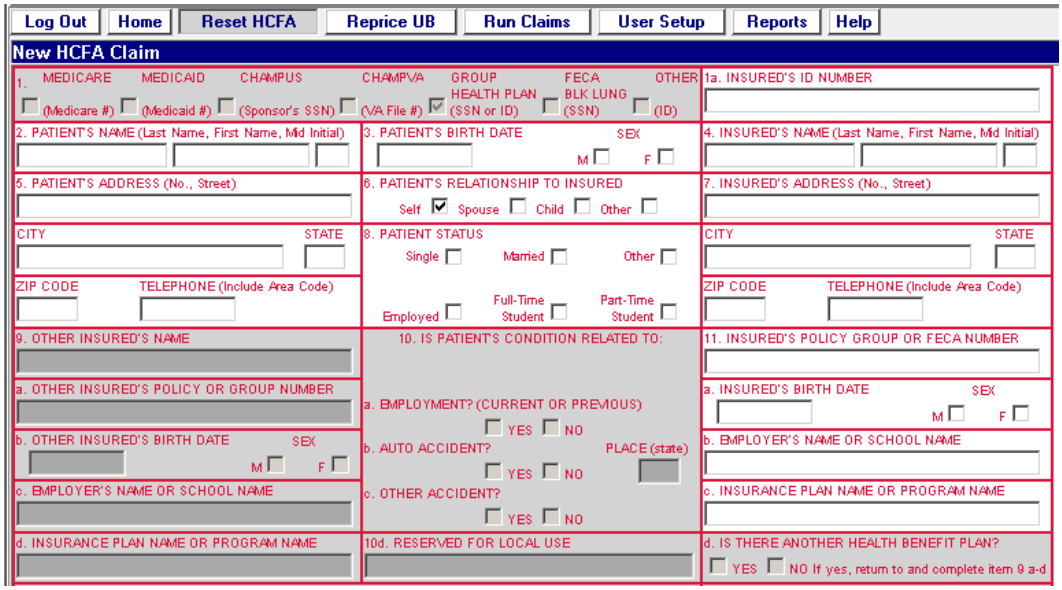
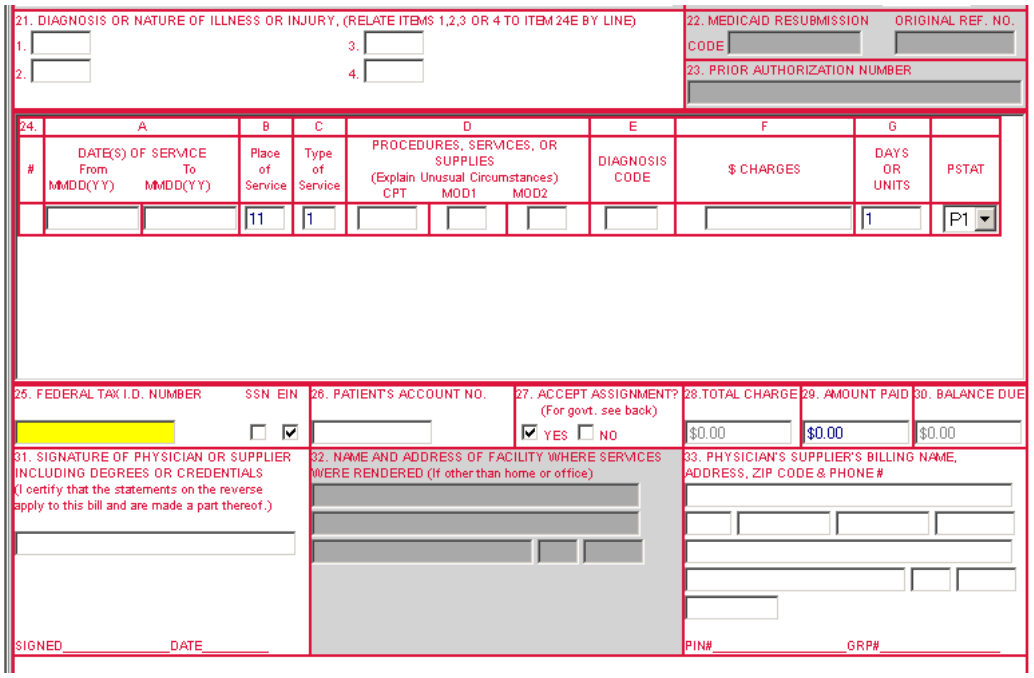
The process was designed so that a practitioner could enter claims data via a web service.

Figure 3. The web service data entry screen looks like a CMS-1500 form and supports 837P transactions.


Log Out
Home
Reset HCFA
Reprice UB
Run Claims
User Setup
Reports
Help
New HCFA Claim
1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)
1a. INSURED'S ID NUMBER
2. PATIENT'S NAME (Last Name, First Name, Mid Initial)
3. PATIENT'S BIRTH DATE SEX
4. INSURED'S NAME (Last Name, First Name, Mid Initial)
5. PATIENT'S ADDRESS (No., Street)
6. PATIENT'S RELATIONSHIP TO INSURED
Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)
CITY STATE
8. PATIENT STATUS
Single Married Other
Employed Full-Time Student Part-Time Student
ZIP CODE TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (CURRENT OR PREVIOUS)
YES NO
a. INSURED'S BIRTH DATE SEX
b. OTHER INSURED'S BIRTH DATE SEX
b. AUTO ACCIDENT?
PLACE (state)
b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT?
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
YES NO If yes, return to and complete item 9 a-d

Conversion of the HCPCS code to the ABC code would occur in the service line area.

Figure 4. A dropdown menu of precise ABC codes appears when a less granular HCPCS code is entered into the service line.


21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER
24. # A DATE(S) OF SERVICE From To MMDD(YY) B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT MOD1 MOD2 E DIAGNOSIS CODE F $ CHARGES G DAYS OR UNITS PSTAT
11
1
1
P1
25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. see back)
YES NO
28.TOTAL CHARGE
29. AMOUNT PAID
30. BALANCE DUE
$0.00
$0.00
$0.00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
33. PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
SIGNED DATE
PIN# GRP#

A CMS-1500 would result. It could be printed out and/or forwarded as an 837P transaction to the health plan—the latter, directly, or through a clearinghouse.

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Figure 5. The web service allows a CMS-1500 to be printed out and mailed and also supports an 837P electronic transaction.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Emma Smith DATE 07/17/04

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED Emma Smith

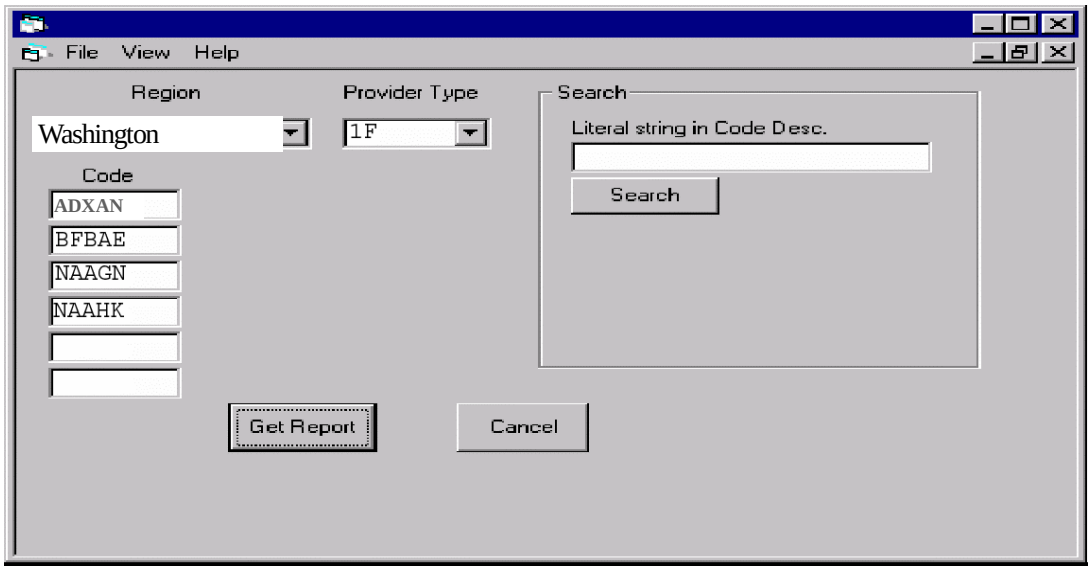
14. DATE OF CURRENT: MM 06 DD 17 YY 04 — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM 09 DD 23 YY 03
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Integrative Health Center
17a. I.D. NUMBER OF REFERRING PHYSICIAN
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES [X] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 428.9 2. 3. 4.
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
07	07	04				11		NAAHK	1F	1	36 40	1				
07	07	04				11		NAAGN	1F	1	163 10	1				
07	07	04				11		ADXAN	1F	1	n/c	1				
07	07	04				11		BFBAE	1F	1	28 00	1				

25. FEDERAL TAX I.D. NUMBER: 12-3456789 SSN [ ] EIN [X]
26. PATIENT'S ACCOUNT NO.: 01EJSmith
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO
28. TOTAL CHARGE $ 227 50
29. AMOUNT PAID $
30. BALANCE DUE $ 227 50

The claim would be received by the health plan and accepted by the health plan's claims adjudication system.

Figure 6. Via OCR or an 837P transaction, the health plan's information system receives the ABC codes and other key data elements (such as the state in which care was delivered and the practitioner type).



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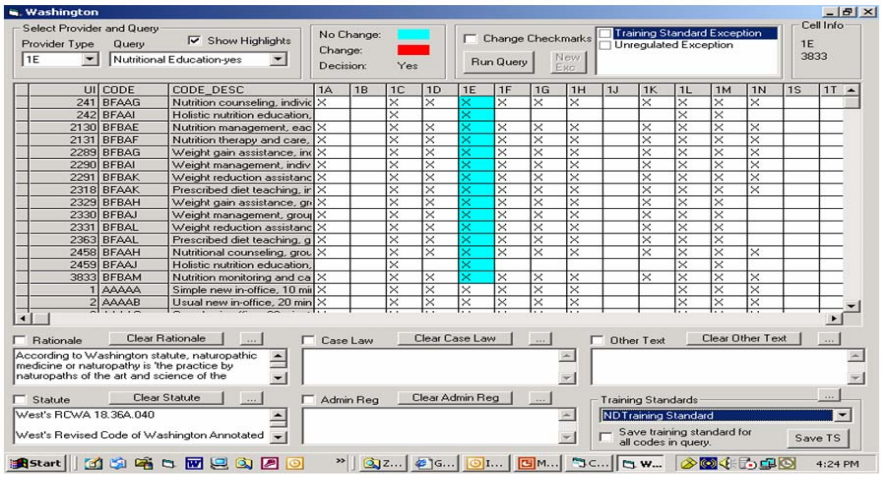
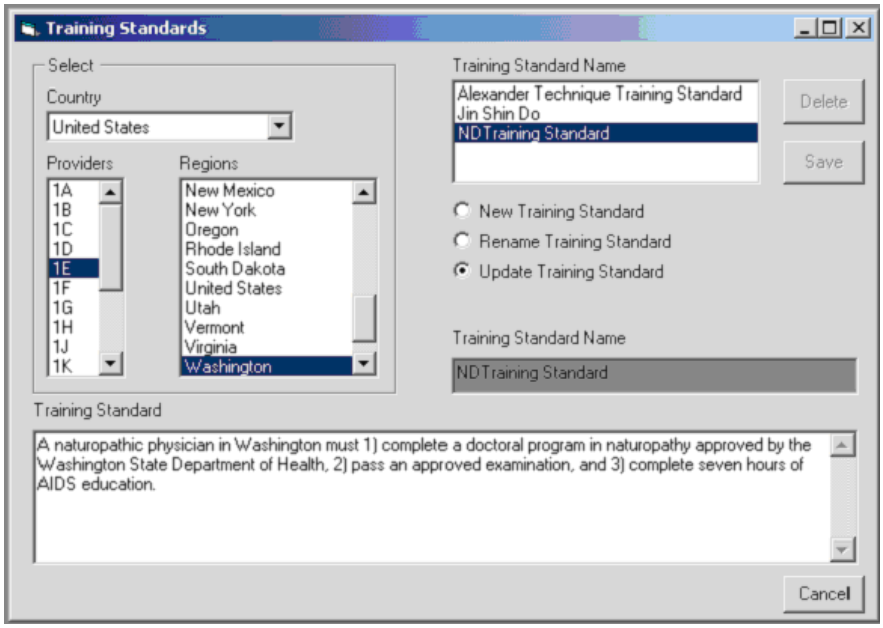
The health plan's auto-adjudication process would verify the legality of care based on practitioner training.

Figure 7. One adjudication step involves mapping an ABC code and practitioner type to statutes, administrative regulations and case law in a specific state.



The system would also verify training requirements:

Figure 8. Another adjudication step involves mapping the ABC code and practitioner type to training and licensing requirements, to verify the necessary practitioner credentials.



Use of data from third parties would support added functionality around clinical efficacy and cost-effectiveness determinations.

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This would make possible line-item auto-adjudication.

If the health plan wanted to conduct more sophisticated analyses, data could drop into the health plan's data warehouses so determinations could be made (for the various subpopulations of covered lives under that health plan) about the relative cost-benefits of care delivered by each practitioner type in each state.

The data could then be queried to support a broad range of mission-critical business processes and to improve healthcare accessibility, quality and cost-management under a broad range of the company's benefit plans.

Although the three-part auto-adjudication initiative has not been fully deployed at the health plan as of this report's writing, it is progressing well. Work completed to date already illustrates the ability of the ABC code set to support

- strategy implementation,
- product and service innovation,
- business process automation,
- credentialing of IHCPs,
- contracting with a broader range of practitioners,
- availability of EDI to new categories of caregivers,
- better collection of healthcare data, and
- identification and promotion of cost-effective care.

Strategy implementation ensures corporate viability and protects U.S. jobs. Product and service innovation addresses pressing societal and human needs, help U.S. businesses and support the U.S. economy. Business process automation reduces operating costs, improve the bottom line, meet the needs of U.S. investors and support economic development. Credentialing of IHCPs improves competition. Contracting with a broader range of practitioners supports consumer choice. Access to EDI functionality among new categories of caregivers supports small business development and facilitates data capture for healthcare research, management and commerce. Identification and promotion of more cost-effective care improves individual and public health and does so at a rational price.

This Report Culminates Eight Years of Work Toward a HIPAA and NHII Standard Designation

Healthcare represents an estimated $1.7 trillion in domestic spending, about 15% of the GDP and an urgent and important human need. Improving the U.S. healthcare system is a national priority. Recognizing between 17% and 33% of every healthcare dollar was spent on administrative processes[17] [18] [19]and that these processes were largely antiquated, Congress passed HIPAA. HIPAA included aggressive administrative simplification mandates and called for standardization of healthcare transactions and code sets.

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To improve the NHII, President George W. Bush issued an Executive Order. It resulted in aggressive consumer-centric and inter-operability requirements for the NHII:[20]

1. Informing clinical practice
2. Interconnecting clinicians
3. Personalizing care
4. Improving population health

Since the HIPAA mandates came first, Alternative Link's interactions with HHS originated and have largely remained with entities involved with implementing that piece of legislation. This report and other Alternative Link communications with HHS are, nonetheless, of critical importance to those charged with establishing standards for the NHII.

HIPAA gave HHS responsibility for designating standard code sets to reflect 1) diagnoses and 2) health interventions.

A quarterly update, submitted to the CMS Office of HIPAA Standards on April 30, 2004, addressed

1. the commercial use of ABC codes in research, management and commerce applications across the U.S. health industry;
2. the evidence of industry demand for ABC codes, the cost-benefit of the codes in HIPAA transactions and administrative simplification, and their compliance with the ten guiding principles for HIPAA standards; and
3. progress on the cost-benefit evaluation of ABC codes, in HIPAA transactions, as a proposed modification to the HIPAA transaction and code set standards, in accordance with 45 CFR 162.940.[21]

This Q2 Fiscal Year 2004 update was preceded by numerous reports to HHS and its advisory authorities on

1. the cost-benefit of ABC codes in HIPAA transactions,
2. the ability of ABC codes to meet the ten guiding principles of HIPAA standards, and
3. the relevance of ABC codes to national and HHS objectives beyond HIPAA.[22]

Since the mid-1990s, Alternative Link has been committed to filling gaps in the HCPCS codes to achieve administrative simplification objectives under HIPAA.

The National Committee on Vital and Health Statistics (NCVHS) had called attention to these gaps and related code set functionality challenges in a formal report to the Secretary of HHS in 1993.

The gaps remained largely unaddressed until the Company developed the ABC code set.

<u>The DSMOs Began Reviewing ABC Codes in 1997</u>

As early as 1997, ABC codes were provided to the organizations that evolved into the current Designated Standard Maintenance Organizations (DSMOs). At the time, the HIPAA transaction and code set standard-setting process was still evolving.

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These standard-setting organizations included the following:
1. American National Standards Institute's Accredited Standards Committee X12 (www.x12.org)
2. Dental Content Committee of the American Dental Association (www.ada.org/goto/decc)
3. Health Level Seven (www.hl7.org)
4. National Council for Prescription Drug Programs (www.ncpdp.org)
5. National Uniform Billing Committee (www.nubc.org)
6. National Uniform Claim Committee (www.nucc.org)

The codes were brought to the attention of HHS on July 7, 1998, within the 60-day public comment period associated with the first HIPAA Notice of Proposed Rule Making (NPRM): "Health Insurance Reform: Standards for Electronic Transactions."[23]

ABC Codes Were Addressed in the Final Rule that Established the Initial HIPAA Code Sets

The need for CAM codes developed by Alternative Link was addressed in the Final Rule published in the Federal Register on August 17, 2000. At the time HHS designated the first group of standard code sets for diagnoses and health interventions, ABC codes were not viewed as sufficiently studied and deployed to support their mandated use.[24] [25]

In the Final Rule, the HHS Secretary adopted the following diagnostic and health intervention code sets as the standards under HIPAA:[26]

1. ***International Classification of Diseases, 9th Edition, Clinical Modification, (ICD-9-CM), Volumes 1 and 2*** (including ***The Official ICD-9-CM Guidelines for Coding and Reporting***), updated and distributed by HHS, for diseases; injuries; impairments; other health related problems and their manifestations; and causes of injury, disease, impairment, or other health-related problems.

2. ***International Classification of Diseases, 9th Edition, Clinical Modification, (ICD-9-CM), Volume 3 Procedures*** (including ***The Official ICD-9-CM Guidelines for Coding and Reporting***), updated and distributed by HHS, for interventions taken for diseases, injuries, and impairments on hospital inpatients, reported by hospitals, e.g., prevention, diagnosis, treatment, and management.

3. ***National Drug Codes*** (NDC), updated and distributed by HHS, in collaboration with drug manufacturers, for drugs and biologics.

4. The CMS[27] ***Healthcare Common Procedure Coding System*** **Levels I and II**, incorporating the American Medical Association's (AMA's) ***Current Procedural Terminology, Fourth Edition*** (CPT-4) for physicians[28] and certain other health practitioners; the American Dental Association's ***Code on Dental Procedures and Nomenclature*** for dental services; and HCPCS codes updated by CMS in coordination with the Blue Cross/Blue Shield Association (BCBSA) and the Health Insurance Association of America (HIAA, now America's Health Insurance Plans or AHIP), for other health-related services such as physical and occupational therapy

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services, radiological procedures, clinical laboratory tests, other medical diagnostic procedures, hearing and vision services, and transportation services including ambulance; and other substances, equipment, supplies, or other items used in health care services, including medical supplies, orthotic and prosthetic devices, and durable medical equipment.

To support national standards, HHS precluded the use of ***HCPCS Level III*** or local codes in HIPAA transactions, effective December 31, 2003. (Local codes were used by Medicaid programs and other health plans to fill gaps in the other code sets to support the financing, administration and delivery of care that met population health needs relevant to state-specific beneficiary populations.)

HIPAA Regulations Anticipated the Need to Maintain and Modify the HIPAA Code Sets

For this and other reasons, the initial selection of HIPAA code sets was not meant to preclude the ongoing maintenance of, or modification to, those code sets.[29] [30]

The need for other coding authorities was suggested in Section 162.1002. It offered comments clarifying the usage of other national code structures as follows:

> Comment:
>
> Although there was wide support for the code sets that were proposed, a number of commenters pointed out that additional code sets were needed to cover some health services recorded in administrative health transactions. ***One commenter mentioned that the code sets proposed as standards lacked coverage of alternative health care procedures and recommended that the Alternative Link coding system also be designated as a standard code set.*** Commenters also indicated that none of the proposed standard code sets covered home infusion procedures… One commenter recommended that dental diagnostic codes (SNODENT)…be used as a national standard…
>
> Response:
>
> …***We acknowledge that the coding systems proposed as initial standards may not address all business needs, especially in the areas of alternative health care procedures***, home infusion procedures, and dental diagnoses. Specific shortcomings should be brought to the attention of the code set maintainers. ***The adoption of additional standards may be an appropriate way to fill gaps in coding coverage in these areas.*** Additional code sets must be analyzed by the DSMOs that will make recommendations to the National Committee on Vital and Health Statistics.

The Workgroup for Electronic Data Interchange (WEDI)[31] suggested the following approach in relation to this challenge:

> In order to request changes, we recommend working through the processes described in §§162.910 and 162.940. In the interim, segments exist in the standard transactions which allow for manual processing of services for which codes have not been adopted."

After the Final Rule was published, Alternative Link followed recommendations from DSMO leadership, WEDI experts, CMS contacts and others about how best to proceed with code set evaluation. The Company ensured it had followed the processes described in §162.910[32] and responded when invited by NCVHS to testify about ABC codes and their importance to HIPAA.

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The NCVHS Began Reviewing ABC Codes in 1999

ABC codes were addressed by the NCVHS and its Standards and Security Subcommittee in 1999 and, again, in key meetings between April 9, 2002, and July 24, 2004.[33]

On April 10, 2002, both NCVHS and CMS directed Alternative Link and the American Medical Association to collaborate on ways to incorporate ABC code set functionality into the AMA's CPT code set. The work was unsuccessful primarily because of differing perspectives on intellectual property rights and objective code development and maintenance processes.

On May 30, 2002, having heard testimony about the failure of these discussions, NCVHS asked CMS to review ABC codes a potential subset of its sections of HCPCS.

CMS's review resulted in a 2003 testimony by a CMS staff member to the NCVHS that mentioned favorable ABC code design, but stopped short of recommending the code set as a subset of HCPCS. This CMS staff member also served on the AMA's CPT Editorial Panel.

ABC Codes Have Widespread Availability and Acceptance

Alternative Link's *ABC Coding Manual for Integrative Healthcare* (which is the functional equivalent of the American Medical Association's Current Procedural Terminology [CPT] coding manual) is now in its *sixth edition*. A *seventh edition* will be available before year's end. The commercial use[34]of the codes in research, management and both *manual* and *electronic* commerce applications is supported not only by this coding manual, but also by industry reports (e.g., "Complementary and Alternative Medicine Market Report"), more than 600 publications, an ASCII data file, and an SQL Version 7.0/2000 database.

ABC code set implementers have free access to the "Companion Document Supporting the Use of ABC Codes in Transactions Mandated Under HIPAA." This document is provided in Exhibit G.

Code set users also have access to HIPAA EDI standard transaction testing and certification services to ensure their transactions are HIPAA compliant.[35]

The codes are already part of the National Institutes of Health's (NIH's) U.S. National Library of Medicine's Unified Medical Language System.[36]

They were voted into the American National Standard Institutes' Accredited Standards Committee[37] X12 004022 and are included in the draft implementation guides for ANSI ASC X12 004050.

ABC codes have been reviewed by the Designated Standard Maintenance Organizations (DSMOs)[38] and the National Committee on Vital and Health Statistics (NCVHS).[39]

They were included in the Final Report of the White House Commission on Complementary and Alternative Medicine Policy.[40] [41]

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They are included in the Congressional Record[42] and have been discussed as a topic for future hearings by the Institute of Medicine of the National Academies (IOM).[43]

They have been proposed as measurement tools in CAM research projects by recipients of grants from NCCAM.[44]

They have been proposed as measurement tools in CAM research projects by recipients of grants from the DOD.[45]

They are supported by leadership of the Consortium of Academic Health Centers for Integrative Medicine that includes 22 leading academic health centers and are being promoted in practice based research initiatives across the country.[46]

They are a "recognized" terminology of the American Nurses Association (ANA).[47]

They are supported by the National Association of Clinical Nurse Specialists (NACNS) which has committed to support nursing terminology reviews, e.g., end of life care.[48]

ABC CODE SET COST-BENEFIT TESTING UNDER 45 CFR 162.940

§162.940(a) Request for an Exception[49]

On October 8, 2003, Alternative Link sought an exception from the use of HIPAA code sets to test a proposed modification or maintenance step associated with those standards. Exhibit H provides the regulatory language from the section of the Code of Federal Regulations (45 CFR 162.940) that empowered the Secretary of HHS to permit the commercial evaluation of proposed modifications to the HIPAA standards that could potentially help the standards improve over time.

Alternative Link's desired outcomes from testing under 45 CFR 162.940 included securing

1. HHS clarification of HIPAA code set evaluation criteria, processes, teams and timeframes;
2. an end to delays, inconsistencies and changing criteria in the ABC code set evaluation process;
3. users' rights to use ABC codes in HIPAA transactions after the HIPAA transaction and code set compliance date of October 16, 2003;
4. public access to an essential element of the NHII; and
5. improvements in individual and public health, business and industry efficiencies and socioeconomic development through improved financing, administration and delivery of care within the U.S. healthcare system.

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Noting these desired endpoints, the HHS Office of the Secretary confirmed that ABC codes would be reviewed in an objective, transparent and timely manner and would be concurrently considered as

1. a proposed modification to the HIPAA standards, potentially subject to commercial use and cost-benefit testing (the latter in HIPAA transactions) under 45 CFR 162.940;
2. a subset of HCPCS codes; and
3. a freestanding HIPAA code set.

On January 16, 2003, HHS Secretary Tommy Thompson authorized ABC codes as an exception to the HIPAA standards, under 45 CFR 162.940.

In making an exception to the HIPAA standards, the Secretary directed Alternative Link[50] to focus on the cost-benefit of ABC codes in HIPAA transactions and to identify all potential parties to the cost-benefit evaluation (e.g., registrants) in advance. The Secretary anticipated that ABC codes would be used in conjunction with HCPCS codes. He called for reporting on ABC code performance not only in relation to costs and benefits, but also in relation to the ten guiding principles for HIPAA transactions and code sets. Exhibit I provides the text from the Secretary's authorization and guidance letter.

ABC codes were the first exception requested and granted under 45 CFR 162.940. HHS required Alternative Link to document a favorable cost-benefit associated with ABC codes in electronic commerce and to provide evidence that the codes met the ten guiding principles prior to being named a HIPAA standard. NCVHS recommended a cost-benefit analysis for ICD-10. To Alternative Link's knowledge, no other code set has been required to meet these performance requirements.

Once the exception was granted, the Office of the Secretary delegated oversight of ABC codes to CMS's Office of HIPAA Standards. With this authority, CMS clarified that trading partners of registrants could use ABC codes in HIPAA transactions and could participate in the cost-benefit evaluation of the codes in EDI. Exhibit J provides the text from the CMS letter that confirmed the rights of registrants' trading partners to use ABC codes in HIPAA transactions.

During the same period, the Office of HIPAA Standards guided Alternative Link to

1. overcome an NCVHS concern that any cost-benefit study design, implementation and analysis conducted by Alternative Link might be biased;[51]
2. establish the cost-benefit of ABC codes in electronic data interchange (EDI);
3. enroll (within two 60-day periods) enough representatives (from the length and breadth of the healthcare vertical and continuum of care) to statistically prove the value of ABC codes by individual discipline and code type, over the full range of codes (i.e., provide evidence of cost-effectiveness in every field of IHC addressed by ABC codes, including acupuncture, chiropractic, holistic medicine, homeopathy, indigenous medicine, midwifery, nursing, spiritual and supplies);
4. document exactly how ABC codes were being used under HIPAA (e.g., who was using them, for what interventions, in how many transactions, in what types of transactions, with what cost/challenges, with what benefits/advantages);

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5. document any difficulty code set users might be having in determining whether HCPCS or ABC codes were applicable to a given HIPAA transaction;
6. accommodate ongoing reengineering of ABC codes by various HIPAA coding authorities throughout the demonstration program; and
7. document the effect of each new or duplicate code[52] on the relative cost-benefit of ABC codes in HIPAA transactions.

These guidelines were followed to the degree they were consistent with the Secretary's guidance and CMS, WEDI and RAND precedents for the level of proof necessary to substantiate the cost-benefit of a HIPAA standard.[53] [54]

For example, the approval letter for commercialization and testing under 45 CFR 162.940, issued by HHS Secretary Tommy Thompson on January 16, 2003, indicated the cost-benefit evaluation could be based on one health plan, one healthcare clearinghouse and one provider. Alternative Link views this as a reasonable requirement.

The Company has determined that more government support (e.g., intellectual, financial and public relations resources) would be necessary for Alternative Link to statistically prove the value of ABC codes by individual discipline and code type, over the full range of codes, for the entire length and breadth of the healthcare vertical and continuum of care.

Also, CMS had noted in its own cost-benefit studies that "micro" level quantitative evaluations do not make sense for individual HIPAA standards, because the value of these standards is driven by "macro" level synergies among the standards themselves, among a broad base of users, and in relation to applications developed by industry for these users.

CMS had also noted that HIPAA standards were unlikely to show net benefits until after the third year of deployment. Since the timeframe granted for the cost-benefit evaluation of ABC codes was two years, some level of forecasting was assumed acceptable.

Similarly, the RAND study of "The Costs and Benefits of Moving to the ICD-10 Code Sets" dealt with costs and benefits more "macro" than those associated directly with HIPAA transactions.

Consistent with the CMS precedents, the evaluation was not subject to 45 CFR 162.940 and did not document

- exactly how ICD-10-CM and ICD-10-PCS are being used under HIPAA (e.g., who is using the codes, for what interventions, in how many transactions, in what types of transactions, with what costs/challenges and with what benefits/advantages);
- specific difficulties code sets users might have in determining how or when to convert from ICD-9 to ICD-10 (although it does provide suggestions about ways to reduce difficulties);
- how to deal with potential reengineering of ICD-10 by other parties; or
- the effect of each new or duplicate code on the relative cost-benefit of ICD-10 codes in HIPAA transactions.

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Recognizing that not all of the CMS Office of HIPAA Standards guidelines could be viewed as requirements under 45 CFR 162.940, Alternative Link compiled what the Company views as compelling qualitative and quantitative evidence of the cost-benefit of ABC codes in HIPAA transactions.

Consistent with the CMS, WEDI and RAND precedents, the cost-benefit data also addressed costs and benefits beyond the transactions themselves.

For example, Exhibit K includes information on the benefits of ABC codes in supporting HHS strategies.[55] This exhibit was derived from an Alternative Link response to an HHS request for public comment in the second quarter of 2002.

Exhibit L includes Alternative Link's response to a 2004 request for comments from the National Institutes for Health (NIH) National Center for Complementary and Alternative Medicine (NCCAM). ABC codes offer benefits in the study of CAM safety, efficacy and cost-effectiveness.

Exhibit M includes frequently asked questions (FAQs) and answers about ABC codes, practitioner identifiers, relative value units, legal practice guidelines and training standards. ABC codes are supported by data elements that improve a broad range of research, management and commerce activities associated with and beyond HIPAA.

Exhibit N clarifies the value of ABC codes within the NHII and includes the National Foundation for Women Legislators' "Access to Care" resolution from 2003.

Exhibit O provides ABC code set registrant perspectives on the costs and benefits of ABC codes—perspectives gathered between January and April 2003 under 45 CFR 162.940.

Exhibit P provides early instructions for these registrants (and their trading partners) in deploying ABC codes under HIPAA and focuses on the ability of ABC codes to facilitate comparisons of the economic and health outcomes of conventional, complementary and alternative care, as well as MDs and IHCPs.

Exhibit Q explains the value of ABC codes in stabilizing America's deteriorating healthcare system.

Exhibit R explains how ABC codes fit into the HHS public-private collaboration to improve the NHII.

Exhibit S documents the interactions between the Company, HHS and other authorities involved in the HIPAA transaction and code set evaluation and naming process to highlight prior communications about code set costs and benefits.

Exhibit T provides excerpts from the testimonies given by Alternative Link to the NCVHS to support the evaluation of ABC codes under HIPAA. (It addresses certain costs and benefits, as well as the specific ways ABC codes meet each of the ten guiding principles for HIPAA standards.)

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Alternative Link's Methodology Paralleled That of CMS, WEDI, RAND and Others

Since CMS's Office of HIPAA Standards raised concerns about whether the NCVHS would view Alternative Link's cost-benefit evaluation as impartial,[56] Alternative Link relied on independent experts and their prior studies to establish baseline figures for the cost-benefit of ABC codes in HIPAA transactions and other uses. In doing so, Alternative Link applied a level of qualitative and quantitative rigor the Company views as comparable to that applied in cost-benefit evaluations of HIPAA administrative simplification standards and the NHII by CMS, WEDI, RAND, and other opinion-leading organizations that have issued public domain reports.[57]

To establish utilization rates for interventions reflected by ABC codes and to determine cost and benefit drivers associated with code use in HIPAA transactions, Alternative Link secured data from

1. the May 2004 National Center for Complementary and Alternative Medicine and National Center for Health Statistics' "Complementary and Alternative Medicine Use Among Adults: United States 2002,"[58]
2. the March 2004 RAND study titled, "The Costs and Benefits of Moving to the ICD-10 Code Sets,"[59]
3. the March 2003 RAND dissertation titled, "The Potential of Claims Data to Support the Measurement of Health Care Quality,"[60]
4. the CMS HIPAA "Impact Analysis," last modified on January 31, 2003, that assessed the costs of implementing the HIPAA standards;[61]
5. the CMS "Claims Payment Carrier Activity Directory;"[62]
6. an HHS memorandum from the Office of Inspector General on a "Review of Medicare Providers and Electronic Claims Processing,"[63]
7. David M. Eisenberg's "Trends in Alternative Medicine Use in the United States, 1990-1997: Results of a Follow-up National Survey," New England Journal of Medicine Article,"[64]
8. David M. Eisenberg's "Unconventional Medicine in the United States: Prevalence, Costs, and Patterns of Use,"[65]
9. the "2004 Healthcare Business Market Research Handbook,"[66] and
10. other cited secondary sources.[67]

The 2004 RAND Science and Technology study on "The Costs and Benefits of Moving to the ICD-10 Code Sets," commissioned by NCVHS, quantifies many of the costs and benefits associated with using a new and/or supplemental code set in HIPAA transactions. Since the RAND study addresses many of the generic cost-drivers and benefits associated with adding a new HIPAA code set, Alternative Link is relying on much of the data presented by RAND as a basis for the more "macro" quantitative cost-benefit evaluation of ABC codes. [68]

RAND took a three step approach to its cost-benefit study and

1. identified major categories of costs and benefits,
2. estimated the amount of money involved in the cost category, and
3. characterized and developed a scenario for each benefit category.

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RAND relied on three data sources for its study:

1. Written and verbal testimonies before the NCVHS Standards and Security Subcommittee between April 9 and August 29, 2002.
2. 80 interviews with 90 individuals (including subject matter experts [SMEs] and health industry stakeholders) between April and August 2003.
3. A literature search on public health use of, and limitations in, the HIPAA code sets.

The Cost-Benefit Evaluation of ABC Codes Drew from Sources Beyond Those Used by Earlier HIPAA Cost-Benefit Researchers

Alternative Link followed a similar three-step research approach and supplemented RAND's data with data from the following sources:

1. Written and verbal testimonies before the NCVHS Standards and Security Subcommittee between April 9, 2002, and May 27, 2003, and related communications with the HHS Office of the Secretary and the CMS Office of HIPAA Standards during the same time period.
2. Communications with more than 10,000 entities between August 1996 and September 2004, that included (but was not limited to) leadership and/or SMEs of the following organizations:
    - AHA
    - AHIP (formerly AAHP and HIAA)
    - AMA
    - ANA
    - ANSI ASC X12N
    - CAHCIM
    - DSMOs: ASC X12, DCC/ADA, HL7, NCPDP, NUBC, NUCC
    - HHS: Office of the Secretary, AHRQ, CMS, NIH's NCCAM, OMH
    - NACNS
    - NCVHS
    - NLM/UMLS
    - OPM
    - SNIP
    - WEDI
    - WHCCAMP
3. A literature search that included (but was not limited to) the following topics:
    - Objectives of HHS and its 5-year strategic plan
    - Objectives of, and limitations in, the NHII
    - Objectives of, and limitations in, HIPAA implementation
    - U.S. healthcare statistics
    - High cost diseases and conditions
    - Consumer-driven healthcare
    - Public health use of, and limitations in, the HIPAA code sets
    - Trends in allied and public health, nursing and CAM
    - Palliative care and end of life care
    - Weight and obesity management
4. Qualitative and quantitative research reports from coding SMEs, ABC code set registrants and petitioners, and representatives of five stakeholder groups:
    - Payors and related organizations
    - Healthcare information technology (HCIT) and claims management companies
    - Provider organizations
    - Practitioner associations and members

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- Industry development organizations (e.g., academic research centers, employee benefit consultancies)

Research Methodology Was Adapted to Reflect Code Set Deployment and Evaluation Constraints

Alternative Link adapted the theoretical methodology proposed in the exception request of October 8, 2002, to compensate for "real world" challenges to timely evaluation (including but not limited to):

- CMS and RAND reported limitations in measuring net benefits from HIPAA standards before the fourth year of deployment;
- industry delays in adopting the original HIPAA transaction and code sets, which suggested adoption of ABC codes as an optional code set would be even slower;
- demonstration site resistance to allocating resources to study of an optional code set under HIPAA at a time when the organizations were economically challenged and preoccupied with short-term HIPAA compliance challenges (e.g., resistance to launching a new initiative into work settings already challenged with "initiative overload");
- demonstration site concerns about eliciting opposition from advocates of allopathic and MD-driven care;
- demonstration site resource constraints that precluded time and motion studies, activity-based costing and other bases for quantitative analyses;
- demonstration site difficulty in efficiently coordinating work teams, agendas and calendars within large organizations; and
- demonstration site difficulty transmitting ABC codes to trading partners not yet ready to support EDI and/or the codes

Alternative Link conducted *exploratory* and *qualitative* research with early-adopters of ABC codes. The Company has asked representative registrants and trading partners whether they had experienced or expected to experience more costs or benefits through deployment of ABC codes.

Among these registrants and trading partners, Alternative Link focused on

1. one of the nation's largest commercial health plans,
2. a Medicaid program,
3. a national association of PPOs and HMOs,
4. a Medicare Advantage program,
5. different categories of HCIT companies (including an application developer, a clearinghouse, an IT integrator and a value-added network), and
6. an IHC clinic with a small PPO network.

Data From Demonstration Sites Was Used to Validate Theoretical Models

Alternative Link then conducted *exploratory* and *quantitative* research among these entities to capture preliminary quantitative data on specific areas of costs and benefits associated with implementing the codes in HIPAA transactions.

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Alternative Link used this information in combination with operating data from demonstration sites to construct and then validate cost-benefit models.[69] Elements of these models are presented in text boxes to substantiate certain points made in relation to the reporting guidance provided by the HHS Secretary, as well as the ten guiding principles for HIPAA standards noted under 45 CFR 162.940.[70]

Compelling Early Findings Suggested Further Research Would Not Add Significant Value

The information collected was so compelling that Alternative Link concluded that the cost of distributing surveys to the larger population of registrants and trading partners exceeded the incremental benefits that such surveys would deliver.

The experience of representative registrants and trading partners—when combined with the EDI-related analyses of CMS, WEDI, RAND and others—appeared applicable to the larger population of covered entities and sufficiently compelling to warrant this report and naming of ABC codes as a subset of HCPCS.

ABC CODES OFFER $51 BILLION IN NET BENEFITS, ABOUT 20% OF THE NATION'S COST OF CLAIMS ADJUDICATION

The sections that follow build the case for a 20% reduction in the total national cost of claims adjudication as a result of deployment of ABC codes. ARC Consulting reports $250 billion annually on medical claims paperwork.[71] CMS reports that each year, health plans process 5 billion claims.[72] Other sources cite as many as 9 billion.[73] This suggests the industry overall spends between $28 and $50 to authorize and process each insurance claim and between $14 and $25 per entity in a two-way transaction.

GartnerGroup reports that manual claims-related procedures—including handling referrals, eligibility and benefits inquiries, treatment authorizations and explanations of benefits—can cost anywhere from $10 to $85 per transaction.[74] With EDI the cost could be $1 or less.[75]

PriceWaterhouseCoopers and Milliman & Robertson report that

- health plans spend about $11 per claim to adjudicate, reprice and issue a check with an explanation of benefits;
- HMOs spend between $8 and $11.50 per claim; and
- Practitioners average $8 per claim for check-in, eligibility and billing.[76]

CMS and WEDI have suggested the cost-savings associated with conversion of simple paper-based claims to EDI is between $1 and $3 per entity per direction.[77] Alternative Link's demonstration sites' experience suggests this figure is low by a factor of four, and that a range of $4 to $22 may better reflect the experience of ABC code set registrants and their trading partners.[78] To accommodate for this difference, Alternative Link uses the CMS and WEDI figures in national estimates and the demonstration site figures in case studies.

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Preexisting Qualitative and Quantitative Information Supports the Cost-Benefit of ABC Codes in HIPAA Transactions

Designated HIPAA Code Sets Focus on Allopathic and Conventional Physician & Dental Interventions

According to a March 2004 RAND cost-benefit study of ICD-10, the HIPAA code sets are largely based on medical knowledge from the mid-1970s. As this base of knowledge has evolved over the last three decades, diagnostic and health intervention coding authorities have been challenged to properly reflect new health-related knowledge and practices (in the standard code sets). As a result, in HIPAA's diagnostic code sets, many diagnoses are incorrectly organized, and their etiologies incorrectly reflected.

Similarly, in HIPAA's health intervention code sets, many health-related services and supplies have been overlooked or have been incompletely, inaccurately and imprecisely described. [79]

Unconventional diagnoses and health interventions delivered by practitioners other than MDs are among those least well supported by the HIPAA code sets.

Since conventional interventions delivered by MDs represent a fraction of all health interventions, and since these caregivers represent an estimated 15.3% of all health practitioners,[80] the resulting gap in the HIPAA code sets may be large enough to compromise congressional intent under HIPAA.

Table 17. The HIPAA code sets focus on the practices of about 15.3% of the nation's caregivers.

Hypothesis:	In the U.S., conventional medical and dental practitioners (MDs, DOs, DDSs and DMDs) represent a minority of all health practitioners.	
Method:	Use Department of Labor Statistics, balanced by industry sources, to estimate the percentage of all health practitioners represented by conventional physicians and dentists.	
Data:[81]	Estimate of U.S. Health Practitioners[82] [83]	
	MDs	802,411
	DOs	50,776
	DDSs/DMDs	92,460
	IHCPs[84]	5,239,373
	All Health Practitioners	6,185,020
Calculations:	$(802{,}411_{\text{MDs}} + 50{,}776_{\text{DOs}} + 92{,}460_{\text{DDS/DMD}})/(6{,}185{,}020_{\text{All}})$ = 15.3% physicians and dentists ("MDs")	
	$(5{,}239{,}373_{\text{All-Physicians \& Dentists}})/(6{,}185{,}020_{\text{All}})$ = 84.7% "IHCPs"	

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Conclusion:	Conventional physicians and dentists represent approximately 15.3% of all U.S. health practitioners, yet HIPAA's administrative code sets focus more on their practices than on the practices of the other 84.7% of caregivers.

This situation is compounded by the elimination of HCPCS Level III or local codes. These codes were used by Medicaid programs and other health plans to compensate for gaps in the medical, dental and supply code sets.

In relation to the challenge of retirement of local codes, WEDI suggested codes be added for, and a standards body designated for, emerging fields such as IHC:[85]

> Local codes are often used to support specific processing purposes e.g. pricing, coordination of benefits with Medicaid, Medicare, and other carriers. ***Alternatives must be identified, or some codes must be added to national standards in a timely manner.***
>
> Elimination of payor- and provider-specific local codes may cause delays in processing as payors seek alternative methods of applying edits, unique pricing, and other adjudication logic. Workarounds may rely on manual procedures. Use of Not Otherwise Classified (NOC) codes may increase in response. This may force some types of claim submissions to paper…
>
> Payors will be able to meet implementation readiness dates for most trading partners through mapping of local codes to standard code values…It is further recommended that a single petition be made to standards bodies to address these issues….it is recognized that some outlier codes will require longer implementation timeframes i.e. beyond 10/1/01 payor readiness date. ***This may disproportionately affect the readiness of certain provider types who are less well-supported by current national code structures...***
>
> ***A process to identify, get consensus on, and expedite the introduction of additions to the code standards is needed. This has been recognized by the DHHS.*** Ultimately, more frequent changes to the issuance of code updates may be needed in response to the dynamic health care environment. ***Emerging fields such as alternative health care, genetic therapy, and other non-traditional methods of treatment must also be assigned to a standards body for regulation.*** [86]

ABC Codes Fill Gaps in and Work Seamlessly with HIPAA Code Sets

ABC codes work in conjunction with HIPAA code sets to better reflect health interventions that the HIPAA code sets do not address or address incompletely, inaccurately and/or imprecisely.

ABC codes also replace a portion of the population health management functionality lost through the preclusion of HCPCS III local codes. That is, ABC codes support the financing, administration and delivery of certain health interventions that, while not yet relevant on a national scale, are relevant to the health of selected beneficiary populations.

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Table 18. ABC codes replace critical financial, administrative and clinical management functionality lost with the retirement of HCPCS III local codes.

Fact: In 2003, Alaska Medicaid adopted the following ABC codes to support coding gaps in its behavioral health program:

ABC Code	Alaska Medicaid's Description (Not Including Time Elements)
CDBAQ	Psychological testing, comprehensive, Testing, evaluation and interpretation
CDBAS	Neuropsychological testing, Testing, evaluation and interpretation
CDBAP	Psychological testing, brief assessment, Testing, evaluation and interpretation
CDAEP	Behavior modification training, social skills, individual, Counseling
CDABF	Family involvement training, Counseling
CDAEQ	Behavior modification training, social skills, group, Counseling
CDAJC	Coding support skill, Counseling

Source: Community Mental Health Crosswalk, 12/19/03

On a qualitative basis, the cost-benefit of ABC codes is made clear by their
1. role as a gap-filling code set;
2. compatibility with the preexisting medical and dental code sets; and
3. central function of converting manual business processes (associated with the integrative health interventions represented by the codes) to automated business processes

The baseline quantitative cost-benefit study of ABC codes in HIPAA transactions is straightforward, as it would be in the grocery industry if an entire category of food products (such as all international foods or Italian or Chinese foods) were missing universal product codes (UPCs or bar codes) and had to be manually ordered, stocked and data entered at check out, while supply chain management could be automated for all other food products.

Just as the UPCs on a category of ethnic food products would function seamlessly with the supply chain infrastructure in the grocery industry, so do ABC codes function seamlessly with other standards within HIPAA and the national health information infrastructure (NHII). The infrastructure has gaps, and ABC codes fill those gaps.

With a structure similar to the HIPAA health intervention code sets, ABC codes fit into the same insurance forms, data fields, software applications, information systems and business processes. (The use of ABC codes in a CMS-1500 form and several software applications was illustrated in a previous section: "Historic Background, Basic Case and Regulatory Context for the Report.")

ABC codes are hierarchic 5-character alphabetic codes supported by 2-character alphanumeric modifiers. The format of the HIPAA health intervention codes for services and supplies (the combination of HCPCS I and II) is five alphanumeric or numeric characters followed by a two character modifier.

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The 5-character portion of an ABC code represents a health intervention. In about 92% of cases, ABC codes reflect care that is inadequately reflected in the HIPAA code sets. In these cases, the HCPCS to ABC code relationship reflects a one-to-many mapping. In about 8% of cases, ABC codes were developed to support mapping between type of care and caregiver, legality, clinical efficacy and economic data elements. In these cases, the concepts reflect by the ABC codes parallel the concepts represented by the corresponding HCPCS codes. The design of these ABC codes tends to extend the value of the corresponding HCPCS codes. In relation to IHC, ABC codes almost always offer greater granularity than the corresponding HCPCS codes.

The following HCPCS codes are presented to illustrate the differences in code set granularity. The targeted category of care is parenting education.

These HCPCS codes lack sufficient granularity to make possible an assessment of the legality, medical necessity, cost-effectiveness, training requirement and relative value of the corresponding care.

The code set relationship from HCPCS II and CPT to ABC is a ***one-to-many*** relationship. The information reflected by the ABC codes is more granular than the HCPCS II code and the CPT codes. That is, ABC codes provide more precise descriptions of delivered care.

Table 19. HCPCS codes for IHC may not be sufficiently granular to make clear the kind of healthcare services or supplies that were provided to a patient or patients.

HCPCS II code **S9444** reflects "Parenting Classes, non-physician provider, per session."
CPT code **96154** reflects "Health and behavior intervention, each 15 minutes, face-to-face with the family, with the patient present." (RBRVS units: 0.64)
CPT code **96155** reflects "Health and behavior intervention, each 15 minutes, face-to-face, with the family, without the patient present." (RBRVS units: 0.64)

The precision associated with ABC codes ensures that a more accurate relative value unit can be developed to reflect the financial worth of the intervention. It also supports assessments of legality, medical necessity, cost-effectiveness and essential practitioner training.

Table 20. ABC codes tend to more completely, accurately and precisely reflect IHC. This is essential to documenting, analyzing managing and paying for delivered care.

ABC code **CDADO** reflects "Parent-of-adolescent education individual each 15 minutes, Mental health counseling, Mental health services, Practice specialties."

ABC codes are accompanied by **expanded definitions** that can be electronically loaded into data fields, software applications, information systems—or simply printed out and referred to manually by health plans. These standardized explanations of care reduce the need for claim attachments.

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Table 21. Standardized and expanded definitions of delivered care provide a way to electronically communicate details about care delivery without the need for claim attachments.

The expanded definition for ABC code CDADO is "Teaching a parent or parents and guardian or guardians to understand and promote the physical, psychological and social growth and/or development of their adolescent child or children. Service is billed in 15-minute increments."

Using "Relative Values for Physicians" methodology, Relative Value Studies, Inc., established an RVU of 3.0 for this code and an RBRVS methodology units of 0.47 (a fraction of the CPT RBRVS value).

Table 22. Precision in ABC codes supports assignment of appropriate relative values and the identification and promotion of cost-effective care.

Hypotheses:	A precise ABC code will support a more appropriate payment level than a less granular CPT code.
Method:	Multiply the Medicare CF by the RBRVS units for each code.
Data:	The 2004 Medicare Payment Schedule Conversion Factor is \$37.3374.[87] The RBRVS figure for CPT is .64.[88] The RBRVS figure for ABC is.47.[89]
Calculation:	37.3374_{CF} x ($.64_{CPT\ RBRVS} - .47_{ABC\ RBRVS}$) = $\$23.90_{CPT\ RBRVS} - \$17.55_{ABC\ RBRVS}$ = \$6.35 in savings from use of ABC codes versus CPT codes
Conclusion:	ABC code CDADO would result in charges \$6.35 lower than CPT code 96154.

Using ABC codes and corresponding relative values over less granular HCPCS codes and payments based on UCR charges tends to reduce the cost of care.

ABC codes are frequently developed in batches, around a particular clinical concept. In this case, a distinction needed to be made between individual and group counseling, since the economic and health outcomes of the two interventions could differ, as would the RBRVS units.

Table 23. ABC codes reflect subtle differences in care that generate significant differences in economic and health outcomes. This supports outcomes research and evidence-based healthcare.

ABC code **CDADP** reflects "Parent-of-adolescent education group each 60 minutes, Mental health counseling, Mental health services, Practice specialties." The expanded definition for this code is "Teaching a parent or parents and guardian or guardians in a group setting to understand and promote the physical, psychological and social growth and/or development of their adolescent child or children. Service is billed in 60-minute increments per client."

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A distinction also needed to be made between teaching an adult good parenting and teaching a teenaged parent (who is still a child) how to be a parent.

Table 24. Health practitioner associations and SMEs help ensure the terminology behind ABC codes reflects the practices of their professions, as well as important determinants of cost and clinical outcomes.

ABC code **CDABO** reflects "Teen-parenting education individual each 15 minutes, Mental health counseling, Mental health services, Practice specialties."

The expanded definition for this code is "Teaching a teenage parent or parents skills to understand and promote the physical, psychological and social growth and/or development of his or her child or children. Service is billed in 15-minute increments."

Research conducted by Relative Value Studies, Inc., revealed that the time spent by the practitioner in the counseling session was the same whether the practitioner was counseling one or two teenage parents so the expanded definition for "individual counseling" accommodated the presence of one or two parents.

Here, too, a distinction needed to be made between individual and group counseling.

Table 25. Differences in care, such as individual vs. group counseling, can lead to differences in outcomes. Detecting these differences promotes cost-effective and evidence-based healthcare.

ABC code **CDAIO** reflects "Teen-parenting education group each 60 minutes, Mental health counseling, Mental health services, Practice specialties."

The expanded definition for this code is "Teaching teenage parents in a group setting the skills needed to understand and promote the physical, psychological and social growth and/or development of their children. Service is billed in 60-minute increments per client."

Since an IHCP may have a different approach and may better leverage resources in a group counseling session, a separate code was warranted.

HCPCS II code **S9444** maps to four ABC codes and CPT codes **96154** and **96155** map to more than 60 ABC codes. The relationships between HCPCS and ABC codes are one-to-many, none-to-one and none-to-many.

Thus, for IHC interventions, the ABC codes are more precise and granular than the corresponding HCPCS II and CPT codes.

In addition to offering important precision, ABC codes also differ from HCPCS codes in relation to the code modifiers that support them.

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The 2-character modifier used with ABC codes is normalized, whereas the modifiers used with HIPAA code sets convey multiple concepts and can be confusing for code set users. For example, HIPAA code set modifiers can reflect

- the body region to which a procedure applied (e.g., "left hand, second digit"),
- the context for care delivery (e.g., "item furnished in conjunction with dialysis services"),
- the type of caregiver (e.g., "anesthesia service performed personally by anesthesiologist"),
- the setting of care (e.g., "via asynchronous telecommunications system"), and
- other characteristics of care delivery.

The ABC code modifier always represents the caregiver.

Since the ABC code modifier is ***always*** used for this purpose, it can support one-to-one matching between practitioner training and delivered care.

Table 26. In medically underserved areas, IHCPs are essential to population health management. Practitioner identifiers make clear the necessary qualifications of the caregiver on an intervention-specific and state-specific basis.

Fact:	In 2004, Alaska Medicaid requested and received a new practitioner identifier, "1Y," for master's degree level counselors—a type of caregiver essential to meeting the needs of Alaska's geographically challenged and medically underserved population.

Since each 5-character ABC code listed on an insurance claim form has a corresponding 2-character modifier that indicates the practitioner type, a practitioner with multiple credentials can submit a single insurance claim with a broad range of integrative health interventions.

Without ABC codes—and with provider taxonomy codes still not fully deployed under HIPAA—as many as three CMS-1500 forms or 837P (healthcare claim: profession) transactions would be submitted—each representing a different practitioner type. The lack of corresponding relative values, legal scope of practice information and training requirements would likely result in requirements for attachments and manual review of all three insurance claims, making them all complex and costly.

The ABC code set's use of code modifiers to identify health practitioner competencies is a cost-effective alternative to the "one practitioner identifier per insurance claim form" approach required for paper claims and not yet prevalent use of existing provider taxonomy codes in EDI.

The practitioner identifier reduces the total number of paper-based insurance claims that must be submitted to secure reimbursement for a single patient encounter when the practitioner has more than one credential.

ABC codes also overcome challenges created by the single data field for a provider taxonomy code on a paper claim. When taxonomy codes are used, a map between these codes and the ABC code set's practitioner identifiers is available.

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ABC Codes Offer Value Up and Down the Healthcare "Vertical"

The ABC code set is developed not only on the basis of individual "ABC Terminology and Code Request Forms" submitted by health industry stakeholders, but also on the basis of industry analyses of emerging health markets.

Among the emerging health markets that Alternative Link has been characterizing are

- obesity and weight management
- palliative care (also known as end of life care)
- genetic profiling and counseling
- abstinence and sex education
- culturally competent care

Table 27. Important practices in emerging fields of healthcare can be stifled by incomplete, inaccurate and imprecise coding.

Fact:	ABC code **BFBAK** is for "Weight reduction assistance individual each 15 minutes, Nutrition management, Nutrition services, Multiple specialties." The expanded definition is "Assisting a client in losing weight and/or decreasing his or her body fat. Service is billed in 15-minute increments."

If a Registered Dietician provided the weight management service described above, this ABC code would be followed by a practitioner identifier "1X" to form a "code + modifier" of BFBAK-1X.

If a Nurse Practitioner delivered the counseling, the code and modifier would be BFBAK-1H, since 1H represents that particular nursing profession.

The ABC code and the practitioner identifying code modifier could be used on any patient encounter form (e.g., superbill), insurance claim form (e.g., CMS-1450 or CMS-1500), or data field designed for a 5-character code plus 2-character modifier.

In running his or her practice, setting rates and establishing managed care contracts, the Registered Dietician would refer to the relative value unit (RVU) for this intervention, currently 1.0. RVUs and corresponding RBRVS units are based on practitioner surveys conducted by Relative Value Studies, Inc. (www.rvsdata.com).

Under the "Relative Values for Physicians" (RVU) model, if the Conversion Factor (CF) in the State of Maryland was $5.39, the practitioner could theoretically justify a charge of $5.39 per patient for every 15 minutes of care in a group setting (RVU 1.0 x CF $5.39) and $21.56 for every 15 minutes in a one-on-one setting. If the conversion factor in the State of California was $5.75, the Nurse Practitioner who practiced there could justify a charge of $5.75 per patient in a group setting and $23.00 for every 15 minutes spent counseling a patient in a one-on-one setting. Under the Medicare/Medicaid RBRVS model, the approach would be similar.

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Prior to delivering care, however, to ensure compliance with their respective legal scopes of practice, the Registered Dietician and Nurse Practitioner would each secure an individual list of legally billable ABC codes and corresponding legally deliverable care that reflected their scope of practice in a particular state.

That is, they could each get a list of ABC codes that had been "queried" against the practitioner type (Registered Dietician vs. Nurse Practitioner) and relevant statutes, administrative regulations and case law in the targeted state (Maryland vs. California).

The Registered Dietician would secure a "Practitioner's Guide to Billable Interventions Using ABC Codes: *Registered Dietician in the State of Maryland*."

The Nurse Practitioner would secure a "Practitioner's Guide to Billable Interventions Using ABC Codes: *Nurse Practitioner in the State of California*."

If either practitioner wanted to "recommend a western herb or botanical" (ABC code "**ADXAE**") to enhance patient weight loss, a "Training Addendum" would alert each of the need to document additional training to substantiate their authority to recommend these substances.

In the credentialing and contracting processes, a preferred provider organization (PPO) that was considering including these practitioners in a national network would selectively query a database that included fields for ABC codes, hierarchic descriptions, expanded (clinical) definitions, practitioner identifiers, RVUs, legal practice guidelines and training standards.

This would give the PPO the ability to
1. verify the training qualifications necessary to deliver different types of care,
2. establish a rational and defensible fee schedule, and
3. protect itself from legal exposure that might result if a "participating provider" delivered care beyond his or her legal scope of practice and/or training.

A clearinghouse or health plan would query the same database (looking at the ABC code, the practitioner identifier used as a code modifier, the state in which care was delivered, and legal logic) to automatically assess the legality of care identified on CMS-1500 form or in an 837P transaction.

The organization would then automatically connect each ABC code to the corresponding ICD-9 diagnostic code and clinical logic (e.g., from monographs for an authority on IHC, e.g., Natural Standard [www.naturalstandard.com]) to assess the medical necessity for care.

Finally, the organization would compare the ABC code specific charges on the claim form to RVUs, RBRVS information and/or usual, customary and reasonable charges (UCR data) to determine the appropriate level of reimbursement.

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In this manner, either organization could *fully automate* the processing of insurance claims that would have gone into manual review—were it not for the availability of ABC codes and corresponding practitioner identifiers/modifiers, RVUs, legal practice guidelines, training standards and other data.

By warehousing data from insurance claims and 837Ps from these and all categories of caregivers, a health plan could compile a data set far superior to any currently available.

The resulting data would reflect conventional, complementary and alternative care and would document the relative economic and health outcomes of care delivered by MDs and IHCPs.

With this information, health plans could identify best practices and significantly improve health insurance benefit plan design, managed care and provider contracting, utilization and clinical practice management, claims processing, outcomes research and actuarial analyses.

Ultimately, this would result in more individuals gaining access to the right care and the right place at the right time, at a rational cost.

CMS's "Impact Analysis" is Qualitative and Precedent-Setting

The challenge of conducting more than a qualitative analysis of the cost-benefit of HIPAA and, in particular, of studying a single element of the standard at a time (e.g., a single code set) was noted by CMS in the "Impact Analysis" noted above:[90]

> "It is difficult to assess the costs and benefits of such a sweeping change with no historical experience. Moreover, we do not yet know enough about the issues and options related to the standard that are still being developed to be able to discuss them here. Our analysis, as a result, will be primarily qualitative and somewhat general."
>
> "Assessing the cost of implementing each standard independently would yield inflated costs…overall estimates will be more accurate than individual estimates."
>
> "Assessing the benefits of implementing each standard independently would also be inaccurate. While each individual standard is beneficial, the standards as a whole have a synergistic effect on savings."

Costs and Benefits in "Impact Analysis" Apply to ABC Codes

In its qualitative analysis, CMS identified key costs and benefits associated with implementing the administrative simplification provisions of HIPAA:[91]

> "These costs include
> - conversion/upgrade costs,
> - start-up costs of automation,
> - training costs and
> - costs associated with implementation problems."

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The benefits of EDI include

- reduction in manual data entry,
- elimination of postal service delays,
- elimination of the costs associated with the use of paper forms, and
- the enhanced ability of participants in the market to interact with each other."

Deployment of New HIPAA Standards Involves Mostly One-Time Short-Term Costs

CMS anticipated one-time short-term costs related to conversion and a three-year break-even point.[92]

"The costs of implementing the standards specified in the statute (HIPAA) are primarily one-time or short-term costs related to conversion."

"These costs will be incurred during the first three years of implementation."

The Cost-Benefit of Adding ABC Codes May Be More Favorable Than That of ICD-10

The costs and benefits associated with ***adding*** ABC codes as a supplemental and gap-filling HIPAA standard are, in some ways, similar to the costs and benefits associated with ***switching*** from ICD-9-CM, Volume 3, to ICD-10-PCS.[93]

However, ABC codes not only add coding precision to drive cost-savings, but also support expansion of EDI-related savings and make possible the identification and utilization of more cost-effective health interventions and health practitioners. Since ABC codes and modifiers are the same number of characters as existing HIPAA code sets, they do not require architectural changes to HCIT systems or the NHII as a whole (e.g., as do new ICD-10 codes).

HIPAA Code Sets Do Not Adequately Reflect Practices of 84.7% of Health Practitioners

Statistics on the number of healthcare practitioners and related technical occupations are inconsistent, in part because measurement tools for reporting their activities are limited.

The U.S. Department of Labor[94] reports 6,185,020 individuals in these professions. Other estimates are as high as 10 million.[95]

The Bureau of Labor Statistics identifies IHCPs as 7 of the top 10 and 17 of the top 30 fastest growing occupations in the U.S.[96]

The median and mean hourly wage estimates for allied health, nursing and CAM practitioners are less than half those of MDs.[97]

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The following table provides a breakdown of some health-related occupation titles, numbers and wage estimates.

Table 28. IHCPs generally charge less than MDs charge.

Health Practitioner	Median	Mean
Family & General Practice Physician	$62.79	$65.51
Physician Assistant	$31.09	$30.53
Registered Nurse	$23.12	$23.96
Licensed Practical &/or Vocational Nurse	$15.12	$15.53
Pharmacist	$37.04	$36.13
Pharmacy Technician	$10.70	$11.15
Psychiatrist	$62.95	$65.01
Psychiatric Technician	$12.36	$13.49
Dentist	$59.24	$64.11
Dental Hygienist	$26.59	$27.78
Physical Therapist	$27.56	$28.93
Chiropractor	$31.41	$40.12
Dietician & Nutritionist	$19.79	$20.16
Medical Records & Health Information Technicians	$11.49	$12.49

Source: U.S. Department of Labor, Bureau of Labor Statistics, 2002.

ABC codes describe the practices of more than 3 million IHCPs, including between 2.2 million[98] and 2.7 million nurses[99] and more than 0.3 million CAM practitioners. The codes are being expanded to reflect the practices of an estimated 2.5 million additional IHCPs.[100] A partial list of practitioner types already served by ABC codes was noted in Table 8.

In contrast, the HIPAA health intervention code sets describe the potential practices of an estimated 853,187 active and inactive physicians (i.e., 802,411 MDs and 50,776 DOs)[101] and 92,460 dentists (DDSs and DMDs).[102]

Table 29. The HIPAA code sets have limited information about care delivered by 84.7% of the nation's caregivers.

Hypothesis:	The HIPAA code sets do not adequately represent the care delivered in the U.S.
Method:	Identify the health practitioners adequately served by HCPCS code sets. Identify the health practitioners not adequately served by HCPCS code sets. Compare the number of practitioners adequately served by HCPCS to those not adequately served by HCPCS.
Assumptions:	HCPCS codes adequately serve MDs.
Data:	Refer to Table 17.

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Calculation:	$84.7\%_{IHCPs} / 15.3\%_{MDs}$ = 5.5 times as many IHCPs as MDs $(2{,}700{,}000_{RNs} + 300{,}000_{CAM}) / (802{,}411_{MDs} + 50{,}776_{DOs})$ = 3.5 times as many nurses and CAM practitioners as "MDs"
Conclusion:	ABC codes serve 3.5 times as many practitioners as CPT codes serve, and more than 3.1 times as many as all HCPCS codes serve.[103] [104] [105] [106] ABC codes will soon serve more than 5.5 times the number of practitioners effectively supported by CPT codes.[107] [108] [109] [110]

The resulting gap in the HIPAA standards leaves uncoded or improperly coded an estimated 1.6 billion outpatient IHC patient encounters per year.[111] In comparison, the CPT and HCPCS II codes support coding of about 1.2 billion outpatient visits per year: [112]

ABC Codes Will Generate a 15 Fold Increase in the Benefits of HIPAA Standards

CMS projected annual savings of approximately $1.5 billion per stakeholder group thereafter.[113] [114]

> "Based on this analysis, we have determined that the benefits attributable to the implementation of administrative simplification will accrue almost immediately but will not exceed costs for health care providers and health plans until the third year of implementation."
>
> "The single year net savings for the year 2002 will be $3.1 billion ($1.6 billion for plans and $1.5 billion for providers)."

In comparison, deployment of ABC codes generates an estimated $51 billion in net savings to the U.S. healthcare system, as noted below.

Deployment and Maintenance of ABC Codes Will Cost the Nation $1.1 Billion in Year One and $225 Million Annually Thereafter

The initial acquisition of ABC codes will cost health industry stakeholders $117.2 million.[115]

Data deployment will add $32.4 million the first year.[116]

Annual data updates and maintenance will cost $133.4 million.[117]

Training of full-time coders, part-time coders, code users and health practitioners will add $917.7 million.[118]

Annual training costs will be $91.8 million or 10% of initial training costs.[119]

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ABC Codes Require Minimal Conversions, Upgrades and Automation Start-Ups

The demonstration sites asked to load ABC codes reported that the codes were no more difficult to load and use than standard updates of the HIPAA health intervention code sets and modifiers.[120]

The codes required minimal conversion and upgrade costs and, therefore, negligible incremental start-up costs, except for those associated with data acquisition and loading.

Some basic requirements for using ABC codes included
1. ensuring pre-existing data fields accepted a 5-character alphabetic code plus a 2-character alphanumeric modifier;
2. loading an ASCII data file or comparable file containing ABC codes into the application or system;
3. following the ANSI ASC X12N 004050 implementation guides for HIPAA transactions related to use of ABC codes;
4. ensuring trading partners had taken the above steps;
5. validating and certifying HIPAA transaction capabilities between trading partners (optional);
6. obtaining annual code set updates; and
7. loading new codes.

For entities that were already complying with HIPAA's administrative simplification provisions, most of the costs associated with these steps were incurred whether or not ABC codes were involved. These entities annually loaded updates to HIPAA code sets into applications and systems. They adopted the latest implementation guides as part of continuous improvement of their business processes. None of the entities encountered difficulties in getting data fields to accept the ABC codes. For these entities, the incremental technical deployment costs of ABC codes were negligible. The noteworthy costs were associated with acquisition of data and loading time and manpower.

Data Acquisition Will Cost the Industry $117.2 Million the First Year

Acquisition of relevant ABC codes is a key driver of cost in ABC code set implementation.

Health plans, HCIT companies (including clearinghouses), provider organizations and practitioners need the code set in different forms for different applications.

They can choose among variety of formats:
- ABC Coding Manual for Integrative Healthcare (hard copy and PDF formats)
- ASCII Data File of ABC Codes and Terminology
- HealthIntel Database
- Practitioner's Guide to Billable Interventions Using ABC Codes (>600 versions)
- Relative Values for Integrative Healthcare Using ABC Codes
- Superbill for Integrative Healthcare

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Health plans and clearinghouses benefit from the entire HealthIntel Database, since it supports advanced functionality (e.g., automating claims adjudication using legal, clinical and economic logic). However, these organizations can also process claims using existing business processes by acquiring and loading into their HCIT applications an ASCII data file that includes ABC codes.

Health plans and clearinghouses pay enterprise licensing fees for ABC codes and related data elements. Software developers pay a seat license for each ABC-enhanced software unit sold.

Providers organizations and practitioners can use coding manuals, practitioner guides, relative value books and/or superbills, depending on their operational needs. A PDF version of the coding manual would suffice in most cases.

The cost model is built around acquisition of 1) seat licenses by health plans and HCIT companies (including clearinghouses) and 2) PDF coding manuals by providers and practitioners.

The model assumes the purchase of a PDF by a provider organization would eliminate the need for an employed practitioner to purchase a coding manual, in a 1:1 ratio.

Table 30. Acquisition of the ABC code set will cost the U.S. healthcare system $117.2 million.

Hypothesis:	ABC codes will cost the industry only slightly more than HCPCS code updates.	
Approach:	Identify the cost of purchasing the ABC code set (available through PDF publications and ASCII data file seat licenses).	
	Compare this number to the estimated revenues generated for the AMA through CPT code set publications and ASCII data file seat licenses.	
Assumptions:[121] [122]		
	Number of noteworthy Health Plans & TPAs[123]	2,975
	HCIT, Clearinghouse & Claims Management Companies	5,000
	"Direct Bill" IHCPs 872,200	
	Cost of Seat Licenses for ASCII Data Files[124]	$10
	Cost of ABC Coding Manual in PDF	$60
	Number of Seats/Users Under Enterprise License	500
	Number of Software Application Users/HCIT Vendor	1,000

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Calculations: $2{,}975_{\text{health plans \& TPAs}}$ x 500_{seats} $\$10_{\text{/seat}}$
= $14.9 million in health plan data acquisition costs (Year 1)
$5{,}000_{\text{HCITs}}$ x $1{,}000_{\text{seats}}$ $\$10_{\text{/seat}}$
= $50 million in HCIT code set acquisition costs (Year 1)
$872{,}200_{\text{"direct bill" IHCPs}}$ x $\$60_{\text{PDF coding manual}}$
= $52.3 million in practitioner code set acquisition costs (Year 1)

Conclusions: Health plans, HCITs and IHCPs will spend $117.2 million to acquire ABC codes in Year 1.

AMA revenues from CPT are not known, but estimates (derived from AMA financial statements and public statements from experts such as Senator Trent Lott) range from $18 million per year to more than $70 million per year. Revenues are derived primarily from coding manual sales and ASCII data file seat licenses. Since the "direct bill" user base for ABC codes is approximately equal to that of CPT codes ($872{,}200_{\text{direct bill IHCPs}}$ vs. $853{,}18_{\text{MDs}}$), the estimate of $117.2 million appears substantiated.

Loading ABC Codes Will Cost the Industry $32.4 Million the First Year.

Loading ASCII data files into HCIT systems is straightforward.[125] Occasionally, a data field that is for CPT codes only, and does not accommodate alphabetic characters, will need to be redefined to accommodate the alphabetic format of ABC codes. In no case did a demonstration site report needing to make architectural changes to use ABC codes.

In the cost-benefit model, the cost of deployment is set at 50% of the cost of data acquisition.

Table 31. Initial loading of ABC codes will cost the U.S. healthcare system $32.4 million.

Hypothesis: Loading costs associated with ABC codes are minute in comparison to the benefits of the code set.

Method: Apply the loading costs associated with loading ABC codes into HCIT systems at demonstration sites to the industry as a whole.[126]

Assumptions:[127] [128]

Number of…	
Health Plans & TPAs[129]	2,975
HCIT & Claims Management Companies	5,000
"Direct Bill" IHCPs	872,200

Loading ABC codes costs 50% of code set acquisition for health plans and HCIT companies.
(IHCPs do not have deployment costs. They use PDF coding manuals.)

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Data:	$14.9 million in health plan data acquisition costs (Year 1) $50 million in HCIT data acquisition costs (Year 1)
Calculation:	$14.9 million $_{\text{health plan code set acquisition cost}}$ x 50% = $7.4 million[130] in health plan code set loading costs (Year 1) $50 million $_{\text{HCIT code set acquisition cost}}$ x 50% = $25 million in HCIT code set loading costs (Year 1)
Conclusions:	The health plans and HCITs will spend $32.4 million to load ABC codes in Year 1.

Alternative Link believes the figure of $32.4 million is about twice the current cost of updating HCPCS codes across the industry.

<u>The Initial Cost of Training Coders, Code Users and Health Practitioners Will Be $917.7 Million</u>

This analysis views the training requirements associated ABC codes as slightly more than those RAND reported in relation to ICD-10-CM and ICD-10-PCS. Training for ABC codes is expected to be substantially easier than for ICD-10; however, Alternative Link learned from demonstration sites that an earlier and larger investment in training reduced the scale and cost of implementation challenges.

The assumption of easier training is supported by the fact that ABC codes are more similar to Level I, II and III HCPCS codes than ICD-10-CM and ICD-10-PCS are to ICD-9-CM, Volumes 1, 2 and 3:

- ABC codes supplement HCPCS codes while ICD-10-CM and PCS codes replace ICD-9-CM codes.[131]
- ABC codes are similar in format to HCPCS codes, while ICD-10 codes are relatively dissimilar in format to ICD-9 codes.
- ABC codes easily load into today's insurance forms, data fields, software applications, information systems and business processes. ICD-10 codes do not.
- Claims adjudication logic from HCPCS codes can be more easily carried over to ABC codes than claims adjudication logic for the ICD code sets.
  - The transition from HCPCS to ABC codes involves ***one-to-one*** and ***one-to-many*** mappings, as well as the addition of entirely new codes.[132]
  - The transition from ICD-9 to ICD-10 codes includes ***one-to-one*** and ***one-to-many*** mappings, new codes, and software-challenging ***many-to-one*** mappings.
  - The number of interventions represented by ABC codes is about one-third of the number of interventions represented by HCPCS I and II codes. In 1997, ICD-10-CM offered 19,019 codes in contrast to ICD-9-CM's 12,566. IDC-10-PCS increased the number of codes from 3,500 in ICD-9-CM, Volume 3, to approximately 200,000.

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Table 32. Initial training on the use of ABC codes will cost the U.S. healthcare system $917.7 million.

Hypothesis:	RAND[133] estimates of training costs for ICD-10 understate costs that would be incurred in providing sufficient training to minimize implementation challenges.	
Method:	Use RAND's figures for coders and end users. Use proprietary figures for IHCPs. Interview an HR expert and lead ABC code set trainer about labor rates and training time.	
Assumptions:[134] [135]		
	Number of…	
	Full-Time Coders	50,000
	Part-Time Coders	200,000
	Other Code Users	150,000
	"Direct Bill" IHCPs	872,200
	Hourly Rate w/Benefits (Coders & Users)	$50
	Hourly Rate w/Benefits ("Direct Bill" IHCPs)	$75
	Training Time (Full-Time Coders)	24 hours
	Cost of Lost Work Time (Full-Time Coders)	$1,200
	Training Expenses (Full-Time Coders)	$300
	Training Time (Part-Time Coders)	8 hours
	Cost of Lost Work Time (Part-Time Coders)	$400
	Training Expenses (Part-Time Coders)	$100
	Training Time (Code Users)	4 hours
	Cost of Lost Work Time (Code Users)	$200
	Training Expenses (Code Users)	$100
	Training Time ("Direct Bill" IHCPs)	8 hours
	Cost of Lost Work Time ("Direct Bill" IHCPs)	$600
	Training Expenses ("Direct Bill" IHCPs)	$200
Data:	N/A	

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Calculations:	50,000 $_{\text{FT coders}}$ x ($1,200 $_{\text{lost time}}$+$300 $_{\text{training fee}}$) = $75 million full-time coder training costs 200,000 $_{\text{PT coders}}$ x ($400 $_{\text{lost time}}$ +$100 $_{\text{training fee}}$) = $100 million part-time coder training costs 150,000 $_{\text{code users}}$ x ($200 $_{\text{lost time}}$ +$100 $_{\text{training fee}}$) = $45 million code user training costs 872,200 $_{\text{IHCPs}}$ x ($600 $_{\text{lost time}}$ +$200 $_{\text{training fee}}$) = $697.7 million health practitioner training costs
Conclusion:	The initial cost of training coders, users and "direct bill" IHCPs in use of ABC codes is estimated at $917.7 million

This cost of training is approximately twice the cost reported by RAND in its cost-benefit analysis of moving to the ICD-10 code sets. Alternative Link believes more robust initial training will reduce implementation problems.

Training costs associated with redeployment of ABC codes at Bridges in Medicine, the PPO for a New Mexico Medicare Advantage program, helped to substantiate this model.

Table 33. The cost of training at a Medicare Advantage demonstration site helped substantiate assumptions made in estimating the cost of training nationwide.

Hypothesis:	Training costs at the Medicare Advantage PPO (Bridges in Medicine) are useful in determining whether the national training figures are appropriate.
Method:	Identify the cost of training at Bridges in Medicine and nationalize the costs.
Assumptions:	Bridges in Medicine practitioners are representative of "direct bill" IHCPs nationwide.
Data:	Training (and custom patient encounter forms) cost $200 per IHCP. Each IHCP lost 8 hours of work time in securing training.[136] Each hour of lost work was worth $60.
Calculations:	(8 hours $_{\text{lost time}}$ x $60/hour $_{\text{IHCP rate}}$) - $200 $_{\text{training costs}}$ = $680 cost of training per IHCP
Conclusions:	The estimate of $800 per "direct bill" IHCP is reasonable. The cost of living in New Mexico is lower than the national average. This may account for the lower rate of hourly earnings noted in this demonstration site.

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Reports from Bridges in Medicine suggest the national training costs may be somewhat overstated; however, Alternative Link views the numbers as appropriate given differences in standard of living costs between New Mexico and other regions of the U.S.

Training of New Workers and Continuing Education on ABC Codes Will Cost the Industry $91.8 Million

Each year, a percentage of those familiar with ABC codes will leave their professions and be replaced by new workers. In addition, a percentage will need continuing education on the codes, to refresh their memories and/or address any new codes that may emerge each year with issuance of new versions of the code set.

Alternative Link estimates this annual training and education will cost 10% of the cost of initial training.

Table 34. An estimated $91.8 million in training will be needed 1) to train new coders, code users and health practitioners who enter the workforce, and 2) to provide continuing education on code set updates.

Hypothesis:	N/A
Method:	Multiply the cost of initial training by a percentage of that total that seems appropriate considering workforce (retiring coders, users and "direct bill" IHCPs) turnover and continuing education needs (e.g., due to code set updates).
Assumption:	Annual retraining will cost 10% of initial training.
Data:	Initial training costs were $917.7 million.
Calculation:	10% $_{\text{annual retraining estimate}}$ x $917.7 $_{\text{initial training}}$ = $91.8 million in annual retraining.
Conclusion:	Annual workforce retraining in ABC codes will cost $91.8 million.

Annual Code Set Updates and Loading Will Cost the Industry $133.4 Million

ABC codes are currently issued annually (although Alternative Link is moving toward real time availability through advanced HCIT applications). The cost of data acquisition remains the same, year one and beyond.

However, Alternative Link anticipates that the cost of deployment will drop to 25% of the cost of data acquisition, as coding experts and HCIT departments develop greater familiarity with the code set and updating becomes routine.

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Table 35. Annual ABC code set updates and loading will cost $133.4 million.

Hypothesis: N/A

Method: Calculate annual licensing and PDF acquisition fees (AKA code set updates). Multiply the cost of code set updates by a percentage of that total that seems appropriate considering the learning curve associated with loading ABC codes in the prior year.

Assumptions:[137] [138]

Number of…	
Health Plans & TPAs[139]	2,975
HCIT & Claims Management Companies	5,000
(IHCPs do not have loading costs. They use PDF coding manuals.)	
Cost of Seat Licenses for ASCII Data Files[140]	$10
Cost of ABC Coding Manual in PDF	$60
Cost of Annual Updates and Maintenance	25% of Data Acquisition Cost
Number of Seats/Users Under Enterprise License	500
Number of Software Application Users/HCIT Vendor	1,000

Data: N/A

Calculations: 2,975 $_{\text{health plans \& TPAs}}$ x 500 $_{\text{users}}$ x $10 $_{\text{per seat license}}$
= $14.9 million in health plan in ABC code set update costs (Year 2+)

5,000 $_{\text{HCITs}}$ x 1,000 $_{\text{users}}$ x $10 $_{\text{per seat license}}$
= $50 million in HCIT ABC code set update costs (Year 2+)

872,200 $_{\text{IHCPs}}$ x $60 $_{\text{PDF}}$
= $52.3 million in practitioner code set update costs (Year 2+)

($14.9 million $_{\text{health plans code set update costs}}$ + $50 million $_{\text{HCIT code set update costs}}$)
x (25% $_{\text{estimated loading costs as \% of code set update costs}}$)
= $16.2 million in annual code set loading costs

$14.9 million $_{\text{health plan in code set update costs}}$ + $50 million $_{\text{HCIT code set update costs}}$
+ $52.3 million $_{\text{practitioner code set update costs}}$ + $16.2 million $_{\text{annual code set loading costs}}$
= $133.4 million in annual code set updates and code set loading costs

Conclusions: The annual cost of ABC code set updates and loading for health plans, HCITs and practitioners beyond the first year of code set acquisition and deployment will be $133.4 million.

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The ABC code set redeployment[141] at Bridges in Medicine reinforced the modest costs and substantial benefits associated with the codes and their implementation. The Medicare Advantage PPO's medical director reported the following actual and forecast revenues, costs and net benefits in redeployment of ABC codes for a single practitioner.[142]

Table 36. A Medicare Advantage practitioner broke even by the end of the first year of ABC code set redeployment, working with a new management team. Training was found to be essential to the success of this initiative. Training had not been adequately delivered when the codes were first deployed.

Year	2003	2004	2005	2006	Totals
Insured Population	8,500	21,000	23,100	25,410	N/A
Incremental Revenues Generated Through Use of ABC Codes	$53,750	$99,000	$118,125	$129,938	$400,813
Costs of ABC Code Redeployment[143] Initiative	42,500	5,830	1,600	1,800	51,730
Net Benefits	**$11,250**	**$93,170**	**$116,525**	**$128,138**	**$349,083**

ABC codes offered a significant ROI by the end of the first year.

Table 37. ABC codes generated significant earnings for IHCPs, without adding costs to the health system. This can be helpful in attracting and retaining non-MDs in medically underserved areas.

Hypotheses:	The experience at the Medicare Advantage PPO (Bridges in Medicine) provides evidence that ABC codes will attract health practitioners to areas challenged with medically underserved populations.
Method:	Review the effect of the ABC coding initiative on earnings for "direct bill" IHCPs.
Assumptions:	Each IHCP gained more than 10 visits in 2003 from the ABC coding initiative. Each visit brought a fee of ~$60. Training in ABC coding was not required in 2004.
Calculations:	$10_{\text{extra visits}}$ x $\$60_{\text{/visit}}$ = $600 in increment revenues from the ABC coding initiative $(\$680)_{\text{training losses}}$ + $\$600_{\text{incremental revenue}}$ = ($80) net loss per IHCP in year one $(\$37{,}500_{\text{PPO earnings}})$/ $(25\%_{\text{admin fee}})$ = $150,000 in IHCP earnings $(\$150{,}000_{\text{IHCP earnings}})$ / (28_{IHCPs}) = $5,357 in incremental earnings $\$5{,}357_{\text{incremental earnings}}$ - $\$80_{\text{2003 losses}}$ = $5,277 net earnings over 2003 and 2004

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$61,815 estimated IHCP gross earnings x .20 tax rate after standard deductions
= $49,452 net earnings for IHCPs

$5,277 net earnings / $49,452 net earnings for IHCPs x 2 years
= 5.3% incremental "direct bill" IHCP earnings via ABC codes

Conclusion: The net benefit "per practitioner" of using ABC codes was $5,277 over the two years of study or an average of a 5.3% increase in net income. This is a low estimate because net income is expected to be >10% higher for each subsequent year.

Medicare Advantage did not disclose its savings from IHC displacement of conventional medical care, but expanded the program by 147% over the study period.[144]

ABC codes provide a mechanism for increasing the earnings of health practitioners in medically underserved areas without adding health system costs.

The Medicare Advantage program supported by the Bridges in Medicine PPO has consistently expanded the number of covered lives with access to this IHC benefit. Based on conversations with Ardent Lovelace Sandia leadership (the organization behind the Medicare Advantage program), Alternative Link believes Bridges in Medicine services are displacing higher cost and higher risk conventional medical interventions. Ardent Lovelace Sandia has reported significant financial constraints in other areas of its business. However, the health system has apparently experienced a reduction in medical costs through the IHC PPO and its cost-effective complements and alternatives to conventional medical care.

The Costs of Doing EDI and HIPAA-Compliant Business Should Not Accrue to ABC Codes

For entities that were not EDI-ready and/or HIPAA compliant, the costs associated with deploying ABC codes in an EDI and HIPAA compliant environment were substantial.

Some basic costs included

- securing training in EDI and HIPAA;
- identifying potential trading partners to justify the return on investment (ROI);
- developing EDI deployment and HIPAA compliance plans;
- securing hardware and software;
- securing HIPAA code sets;
- securing and interpreting ANSI ASC X12N implementation guides;
- implementing EDI and HIPAA compliance plans;
- validating EDI and HIPAA transaction capabilities between trading partners;
- assuring HIPAA provisions are included in trading partner contracts;
- obtaining code set updates; and
- updating codes no less frequently than annually.

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The sites that fell into this category were typically IHC practices. While none of these sites was able to become fully EDI ready and HIPAA complaint during the cost-benefit evaluation, the majority were able to transition from having mostly clinical competencies to having a useful combination of financial, administrative and clinical competencies.[145]

ABC codes were the key driver for this transition, since the codes enabled these caregivers to
1. better characterize the types of care they routinely delivered to patients;
2. better document these interventions in medical records and, especially, SOAP notes;[146]
3. develop more rational and defensible pricing based on relative value units;
4. negotiate (managed care) fees with health plans;
5. develop patient encounter forms and/or superbills to reflect these interventions; and
6. provide better documentation to patients and insurers to substantiate billing.

This analysis considers these costs to be the cost of doing business in an EDI and HIPAA environment. The analysis does not view these costs as directly attributable to deployment of ABC codes. Instead, the analysis views ABC codes as an "entry ticket" that makes such clinical and business process improvements possible—a benefit, not a cost, of the code set.

The Cost of Continuous Process Improvement Should Not Accrue to ABC Codes

Securing the ***greatest potential benefit*** from the codes entailed conversion and upgrade costs and, therefore, noteworthy start-up costs.[147] [148] For example, in addition to loading ABC codes, those organizations committed to automated adjudication of claims needed to load certain other data elements that were related to, but not part of, this proposed HIPAA code set.

While none of these sites was able to fully deploy all of these data elements in automated adjudication applications during the cost-benefit evaluation, many were able to adapt key internal processes to make cost-effective use of the data elements.[149]

For example, an IHC clinic used a number of "Practitioner's Guide to Billable Interventions Using ABC Codes" to determine which practitioners to employ and what scope of practice to authorize for each of them.

A health plan that paid claims from these practitioners needed to secure confirmation that billed codes reflected care delivery patterns that were clinically and legally appropriate.

A clearinghouse (addressed in Table 38 below) needed the ABC codes, practitioner identifiers, relative value units, legal practice guidelines and training standards to educate its entire client base about a next generation version of its claims adjudication and repricing applications, as well as its outsourced claims adjudication services.

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Some value-added data elements that were routinely used in administrative simplification in conjunction with the HIPAA code sets (as well as the ABC code set) and that were relevant to this cost-benefit evaluation include

- practitioner identifiers;
- relative values units;
- legal scope of practice assessments (e.g., based on state-specific statutes, administrative regulations and case law);
- licensing, credentialing, training standards for practitioners (nationally, by state and by community);
- usual, reasonable and customary charges (UCR);
- clinical efficacy indicators; and
- cost-effectiveness assessments.

These data elements are ***not*** being proposed as part of the HIPAA standards. They have, however, contributed synergistically to the benefits offered by ABC codes (as well as the other code sets).[150]

Working in conjunction with ABC codes, these data elements generated a significant portion of the measurable benefits of ABC codes. The issue remained whether their acquisition, development and/or deployment was a cost that should be allocated to

1. the cost of deploying the ABC codes themselves or
2. other factors, such as continuous improvement of business processes that were necessary with or without the ABC codes.

In this analysis, these data elements were viewed as part of continuous improvement of business processes that were essential to providers, health plans and healthcare clearinghouses with or without ABC codes.

The analysis further considered that the development and deployment costs of these data elements were ***even higher*** without the use of ABC codes than with the use of ABC codes. This perspective was substantiated in representative demonstration sites noted in this report.[151]

Table 38. Mitchell Medical licensed ABC codes and related data in 2001 to support electronic adjudication of medical injury claims in the automotive insurance industry.

In 2001, Mitchell Medical licensed not only the ABC codes, but also other data elements in the HealthIntel Database, such as relative values, legal information and training standards. The company is the leading adjudication application developer and outsourced adjudicator of automotive injury claims in the U.S. Although Mitchell Medical uses HIPAA-compliant transactions and code sets, the company operates outside the HIPAA-regulated health insurance market. In the automotive insurance market, where Mitchell Medical does business, HCIT systems are reliant on shared transaction and coding standards, just as these systems are in the health insurance market. The company incurred the cost of the HealthIntel Database as part of its ongoing product, service and business process improvement initiatives.

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An estimated 60% of claims that involve automotive injuries are submitted by IHCPs (and these IHCP categories are supported by ABC codes). About 70% of transactions related to automotive injuries are processed using Mitchell Medical solutions, representing about 3.7 million of the estimated 5.3 million non-fatal injuries each year.[152] Each "accident claim" involves about 15 provider encounters.[153] Thus, Mitchell Medical solutions address more than 55 million reports of medical encounters, 60% of which originate from IHCPs. When Mitchell Medical finishes deploying ABC codes across all its application and outsourcing solutions, the code set will be used in 76.8 million line-item transactions a year that originate from the same IHCPs who serve the health insurance market.[154]

This perspective differs from the position taken in the RAND cost-benefit analysis for ICD-10-CM and ICD-10-PCS because the ICD-10 code sets are relatively incompatible with the insurance forms, data fields, software applications, information systems and business processes used with today's HIPAA code sets.[155] [156]

Independent of the data elements described above, ABC codes fit seamlessly into today's insurance forms, data fields, software applications, information systems and business processes.

Implementation Challenges Will Generally Result From Inherent Business Process Flaws, Not ABC Codes

As CMS anticipated in its "Impact Analysis," the implementation of ABC codes introduced some complexity as health plans, clearinghouses, provider organizations and practitioners attempted to improve business processes using ABC codes.

Among the challenges reported were

- difficulties quantifying net benefits from deployment because of the "first mover disadvantage" phenomenon associated with investing before benefits could be accrued through synergies with trading partners;
- ideological differences and internal strife among proponents of conventional, complementary and alternative care;
- political concerns about "rocking the boat" with an IHC code set;
- coordination challenges among departments of large organizations, as department heads sought the benefits of ABC codes but wanted other functional areas to pay for them;
- resistance to allocating resources to study of an optional code set under HIPAA at a time when the organizations were economically challenged and preoccupied with short-term HIPAA compliance challenges (e.g., resistance to launching a new initiative into work settings already challenged with "initiative overload");
- resource constraints that precluded time and motion studies, activity-based costing and other bases for quantitative analyses;
- difficulty in efficiently coordinating work teams, agendas and calendars within large organizations;
- difficulty transmitting ABC codes to trading partners not yet ready to support EDI and/or the codes;

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- difficulty dealing with ad hoc research and training requirements;
- concern with potential payment delays and denials and associated "fall out" with trading partners; and
- an initial surge of requests for additional information both about delivered care and the ABC codes that described that care.

Alternative Link believes the majority of these challenges are associated with the "optional" status of ABC codes. That is, the Company believes mandated code set use would eliminate the bulk of difficulties.

Other difficulties are viewed as typical within large organizations, e.g., infighting over which budget will be tapped for a new initiative or worrying about "rocking the boat" with a politically sensitive undertaking.

In general, Alternative Link found that proper training of executives, professionals, practitioners and administrators consistently alleviated the challenges.

Table 39. Employee training is essential to avoiding implementation challenges and ensuring proper use of ABC codes in research, management and commerce applications.

A TPA (subsequently acquired by Safeco) employed a claims administrator who was concerned that claims that included ABC codes might be rejected if the adjudication system was not able to link the ABC code to a diagnosis for which the care was already viewed as appropriate. Rather than address the clinical logic in the system, the administrator coded every claim for approximately 18 months with a single diagnosis that had worked in the past. The problem was not detected until queries were run to assess the economic and health outcomes of different approaches to care. At that point, queries returned no data until a query was run on the one diagnosis this administrator preferred. No conclusions could be drawn from 18 months of data because the ABC codes and the single diagnosis were clinically unrelated.

Training on use of ABC codes worked best when it was properly coordinated among different levels and departments within a single organization and among the corresponding levels and departments of key trading partners.

For example, having encountered the above challenges, Alternative Link concurrently educated a national health plan, its favored HCIT systems vendor, and the vendor's other health plan clients. Similarly, Alternative Link concurrently educated the members of the Bridges in Medicine PPO and the management of Ardent Lovelace Sandia's Medicare Advantage program.

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Table 40. Implementation challenges can result from different schedules for code set deployment across HIPAA trading partners.

Ardent Health Services/Lovelace Sandia Health System's Medicare Advantage program used the ANSI X12N 835 to 4,332 payments to CAM practitioners.

Challenges occurred when Ardent Lovelace Sandia outsourced claims payments to a TPA that did not support ABC codes.

Until Ardent directed the TPA to load ABC codes, practitioner payments were interrupted. This took more than three months to resolve. The challenge was resolved when the TPA loaded the codes. Once that occurred, claims were processed more efficiently than ever.

During the troubleshooting period, this Medicare Advantage program learned that it could adjust payment levels by approximately 20% by using ABC codes' relative values instead of CPT codes' relative values and associated Medicare fee schedules.[157]

Alternative Link found implementation challenges lessened once training materials were adapted for different types of code set users, and deployment was either 1) conducted solely on a department specific basis or 2) entirely through a "top down" mandate.

Table 41. Other implementation challenges can result from code set deployment on a tactical level, without sufficient strategic oversight.

The medical policy team at a national health plan wanted to deploy ABC codes company-wide to support a broad range of corporate initiatives.

These initiatives ranged from claims adjudication reengineering to practitioner credentialing to new benefit plan design to reducing health disparities among medically underserved populations.

In some cases, the health plan's department heads were so focused on the effects of the codes on their own business units and processes that they did not support the corporate initiatives or timeframes necessary to achieve the full benefits of the code set across the organization.

Again, Alternative Link viewed these challenges as routine for most U.S. businesses and did not view the costs of these challenges as rightly accrued to ABC codes.

Deployment of ABC Codes Will Generate U.S. Healthcare System Savings of $51 Billion

The U.S. healthcare system will save $17.3 billion through conversion of all IHC claims to clean EDI claims. Of this $17.7 billion, the elimination of attachments will generate savings of $3.26 billion . Eliminated communications will generate $7.8 billion in savings

Another $3.1 billion will result from administrative efficiencies gained from business process reengineering in areas other than EDI.[158]

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Use of cost-effective IHC will save more than $15.0 billion.

Reliance on more precise relative values derived from ABC codes will generate more than $7.7 billion in savings over relative values associated with less granular HCPCS codes.

Elimination of extra claims from practitioners with multiple credentials will save $478.6 million.

Health plans will save $8.6 billion through elimination of MD administrative fees associated with oversight of, and billing on behalf of, IHCPs when the latter could use ABC codes to direct bill.

Expansion of EDI Will Save More Than $17.3 Billion

The baseline figure for savings associated with converting IHC claims from complex paper and complex EDI claims to clean EDI claims is $17.3 billion.

Table 42. Savings of more than $17.3 billion will result from extending the value of EDI to "direct bill" IHCPs and thereby eliminating complex insurance claims that require manual troubleshooting.

Hypothesis:	More than half a million qualified IHCPs have been excluded from the benefits of EDI because of the gaps in the HCPCS code sets. This has resulted in EDI-related claims management inefficiencies of about 6.9% of the total cost of claims management in the U.S.
Method:	Estimate the cost-savings associated with enabling "direct bill" IHCPs to submit clean EDI claims instead of a mix of complex paper and complex EDI claims.
Assumptions:	Claims management costs in the U.S. are $250 billion per year.[159] 872,200 IHCPs have rights to direct bill. Each "direct bill" IHCP sees 8 patients per day. 46% of patient visits to "direct bill" IHCPs are billed to health plans. 5% of these billed visits are billed using EDI. These complex EDI claims cost $12 to adjudicate. The remaining 95% of those billed to health plans are complex paper claims. These complex paper claims cost $23 to adjudicate. For purposes of this calculation only, none of the "direct bill" IHC claims are viewed as routing through an MD and being marked up with an administrative fee.
Data:	872,200 IHCPs
Calculation:	$(872{,}200_{\text{IHCPs}} \times 8_{\text{patients/day}} \times (365_{\text{days/year}} - 104_{\text{weekend days}} - 15_{\text{holidays}})$ = 1,716,489,600 annual patient visits to "direct bill" IHCPs $1{,}716{,}489{,}600_{\text{annual patient visits to IHCPs}} \times .46_{\text{billed to health plans}}$ = 789,585,216 claims from "direct bill" IHCPs

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	789,585,216 $_{\text{claims from IHCPs}}$ x ((.95 $_{\text{complex paper}}$ x \$23 $_{\text{complex paper adjudication}}$) + ((1-.95) $_{\text{complex EDI}}$ x (\$12 $_{\text{complex EDI adjudication}}$))
	= \$17,252,436,970 in savings associated with converting all "direct bill" IHC claims to clean EDI claims
Conclusion:	The EDI-related cost of not representing the practices of "direct bill" IHCPs in the HCPCS codes is \$17.3 billion or 6.9% of the total cost of claims management nationwide.

This figure is about 7% of the estimated \$250 billion cost of claims management nationwide.[160] Claims from IHCPs are generally treated as complex claims because the HIPAA codes that are used in these claims do not provide or map to essential information about the nature, legality, clinical efficacy or cost-effectiveness of care. As a result, IHC claims are likely to require extra manual handling—at considerable cost.

Table 43. A national health plan's experience with claims from three types of IHCPs helped substantiate the scale of cost-savings offered by converting complex paper and EDI claims to clean EDI claims.

Hypothesis:	The experience at a national health plan provides evidence that ABC codes will save billions of dollars in claims management costs.
Method:	Calculate the cost-savings associated from conversion of complex paper and complex EDI claims at a national health plan to clean EDI through use of ABC codes for "direct bill" IHCPs.
Assumptions:	Insured lives are evenly distributed across the U.S. Uninsured lives are evenly distributed across the U.S. All claims flagged by the health plan are complex paper claims. Complex paper claims cost \$23 to adjudicate. Clean EDI costs \$1 to adjudicate.
Data:	The health plan's insured population is 13.4 million.[161] The 2003 estimated national population is 290,809,777. The 2003 estimated national uninsured population is approximately 45 million.[162] Claims data were queried for three relatively mainstream CAM practitioner types: 1. Acupuncturists 2. Massage Therapists 3. Naturopaths These three practitioner types represent 11.9% of "direct bill" IHCPs.

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Calculation: (Refer to the associated file named "DemoReportQuantCalc," Tables 43 and 43a.)

The health plan's cost-savings from conversion of these flagged complex paper claims to clean EDI claims were calculated at $2.4 million.

Cost-savings for this health plan were nationalized, first based on the health plan's insured lives as a percentage of the nation's insured population, and then based on the insured population in each state in which the IHCPs could legally deliver care.[163] [164] [165] [166]

The resulting nationalized cost-savings for the three IHCPs were $43.8 million.

((872,200 $_{\text{IHCPs}}$) / (104,000$_{\text{acupuncturists + massage therapists + naturopaths}}$))
x ($43.8 million $_{\text{national savings}}$)
= $367.4 million in cost-savings for all "direct bill" IHCPs

Challenge: This number was off by a degree that suggested the "direct bill" IHCP claims were not being fully captured by the health plan. The health plan's experience should have nationalized to the $17.3 billion in EDI savings. Since it did not and all assumptions had valid sources, the model needed to account for what must have happened to the claims the health plan never saw.

Approach 2: A new set of data points was identified to determine where the "unseen" claims had been routed.

The 2002 data from an HHS CAM survey conducted and reported by CDC and NCCAM[167] suggested the following utilization rates for the three "direct bill" IHCPs:

Acupuncturists:	1.1%
Massage Therapists:	5.0%
Naturopaths:	0.2%

If patients who visited these IHCPs made an average of 4 visits per year, the number of claims the health plan should have seen would be as follows.

Calculation 2: 245,809,777 $_{\text{insured}}$ x Rate $_{\text{NCCAM/CDC survey}}$ x 4 $_{\text{visits/year}}$ x .46 $_{\text{billed to health plans}}$
x (13.4 million $_{\text{health plan beneficiaries}}$ / 245,809,777 $_{\text{insured}}$)

IHCP	Theoretical	Actual	Claims Still Missing
Acupuncturists:	271,216	61,944	209,272
Massage Therapists:	1,232,800	30,252	1,202,548
Naturopaths:	49,312	16,344	32,968

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Challenge 2: This number was still off by too great a degree.

Approach 3: Alternative Link revisited the secondary data sources and found that reported CAM expenditures attributable to third party payors did not note the payor type. One demonstration site (Mitchell Medical) was from the automotive insurance sector. This implied that CAM statistics widely attributed to the mainstream health insurance arena were likely reflective of multiple insurance arenas: health, workers' compensation, automotive and other P&C.

Conclusion 2: Two factors can account for the health plan's expected but "unseen" claims. Neither factor undermines the potential cost-savings of making clean EDI available to "direct bill" IHCPs via ABC codes.

The first factor is capitated CAM "carve outs" and "discount programs." These specialty health plans mark-up inefficiencies in the claims processing arena to secure a margin on those efficiencies, thus creating further inefficiencies. That is, a specialty health plan will charge a premium over the primary payor's inefficient business process costs. A single complex paper claim that would add $23 to the primary payor's operating costs is outsourced at $23 plus the primary payor's opportunity cost of handing the inefficiency. This institutionalizes the inefficiency and creates a data silo that prevents the primary payor from identifying cost-effective IHC that could replace less efficient approaches to care.

The second factor is other forms of "health insurance" that are paid by payors other than conventional health plans. Among these are workers' compensation plans, automotive insurance companies and others.

In revisiting the sources for the 46% of IHC claims billed to insurance, evidence of this distribution of IHC claims across these insurance categories was apparent.

Conclusion 3: The experience of the national health plan revealed inefficiencies in the structure of health insurance which, once accounted for, substantiated the $17.3 billion in EDI-related cost-savings. That sum, however, is distributed across a range of insurance types.

An IHCP's practice efficiencies depend on use of the same health information infrastructure standards across insurance types. Resolution of inefficiencies in mainstream healthcare is dependent on eliminating financial, administrative, delivery and data silos across insurance models.

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ABC codes help by offering a common metric across insurance/payor categories to allow for complete, accurate and precise measurement of the financing, administration and delivery of care to support identification of best practices regardless of the insurance/payor context.

The definition of mainstream health insurance limits the ability of policymakers to see the true nature of healthcare challenges and excess system costs. In the case of IHC, the system inefficiencies associated with the absence of EDI capabilities remain $17.3 billion.

ABC codes save money for three reasons:
1. They answer questions about the type of care that was delivered.
2. They eliminate questions about the credentials of the caregiver.
3. They provide a rational basis for payment.

Resources are already available to extend the automation into an instantaneous determination of clinical efficacy. For example, Natural Standard (www.naturalstandard.com) offers monographs that include an A to F grading system that reflects the level of clinical efficacy that has been demonstrated for a broad range of CAM interventions. These monographs and corresponding grades can be mapped to ABC codes as a starting point for medical policy setting and auto-adjudication.

Over time, such assessments can be based on a health plan's own actuarial data and can reflect cost-effectiveness in addition to clinical efficacy.

Covered entities can achieve significant cost-savings through promotion of ABC coding from even a small percentage of IHCPs.

Table 44. Secondary data on chiropractic billing patterns helps substantiate the scale of cost-savings associated with converting complex paper and EDI claims to clean claims.

Hypothesis:	Giving one type of "direct bill" IHCP clean EDI capabilities will generate substantial health system cost-savings.
Method:	46% of chiropractic charges are paid by insurers.[168] [169] 54% of chiropractic charges are paid by patients.[170] [171]
Assumptions:	For the purpose of this calculation, specialty health plans with capitated or discounted payment models, are ignored (since they institutionalize administrative and medical management inefficiencies and, if accounted for, would suggest even greater cost-savings through use of ABC codes by primary payors). A 1:1 ratio exists between patient visits and charges (i.e., 46% of visits are for insured patients and 54% of visits are for uninsured patients and both groups are charged the same fees for care). 5% of chiropractic claims are submitted to insurers electronically.[172]

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	2.3% of patient visits are billed to insurers using EDI (.46 $_{\text{insurer paid}}$ x 5% $_{\text{complex EDI}}$). 43.7% of patient visits are billed to insurers using paper-based claims. (.46 $_{\text{insurer paid}}$ x 95% $_{\text{complex paper}}$). Conversion of complex EDI to clean EDI saves $11 per claim.[173] Conversion of complex paper to clean EDI saves $22 per claim.[174]
Data:	35.1 million chiropractic visits occur each year in the U.S.[175] [176]
Calculation:	((2.3% $_{\text{complex EDI}}$ x $11 $_{\text{complex EDI savings}}$) + (43.7% $_{\text{complex paper}}$ x $22 $_{\text{complex paper savings}}$)) x 35.1 million $_{\text{chiropractic visits}}$ = $348.1 million.
Conclusion:	Giving chiropractors clean EDI capabilities would generate system cost-savings of $348.1 million.

Given the adjustment period granted to covered entities vis-à-vis new standards, these organizations can deploy ABC codes on an incremental basis, starting with the practitioner types that offer the greatest cost-saving potential.

Eliminated Attachments Will Save More Than $3.26 billion

Submission of attachments adds significant cost to the claims management process.

By standardizing lengthy explanations of delivered care (called expanded definitions) and by making these explanations available electronically with the ABC code set, Alternative Link has created a way to avoid attachments for the majority of IHC interventions. (Exhibit F illustrates an ABC code and a corresponding expanded definition.) Expanded definitions of care can be electronically loaded into HCIT systems, along with ABC codes, and can be queried or viewed electronically by claims adjudication systems or personnel to support coverage and reimbursement decisions.

Table 45. Standardized and expanded definitions that are part of the ABC code set reduce the need for claims attachments and save an estimated $3.26 billion by making possible the submission of clean EDI claims.

Hypothesis:	The standardized descriptions of care included in the ABC code set's "expanded definitions" field offer substantial system cost-savings.
Method:	Calculate the cost-savings of converting complex paper claims to simple paper claims for the percentage of "direct bill" IHCP claims that are likely to require attachments.

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Assumptions: Claims attachments add a minimum of $11 per claim to the cost of claims adjudication.[177]
Each "direct bill" IHCP sees 8 patients per day
Each "direct bill" IHCP works 246 days per year
46% of "direct bill" IHC patient visits are billed to insurers
75% of "direct bill" IHC claims need attachments

Data: 872,200 "direct bill" IHCPs

Calculation: $872{,}200_{\text{IHCPs}} \times 8_{\text{patient visits per day}} \times 246_{\text{workdays per year}} \times .46_{\text{insurer paid}} \times .75_{\text{attachment probability}}$
= 592.2 million claims from "direct bill" IHCPs, that require attachments

592.2 million $_{\text{IHCP claims w/ attachments}} \times .50$ probability of elimination of attachment via use of ABC codes
= 296.1 million avoided attachments

296.1 million $_{\text{claims made clean}} \times \$11_{\text{savings/claim}}$
= $3.26 billion in savings from eliminated attachments

Conclusion: Of the 592.2 million IHC claims that require attachments, 296.1 million could become "clean" claims through use of ABC codes.

The system cost-savings represented by the expanded definition-related functionality of ABC codes is $3.26 billion.

The volume of claims that requires attachments is significant, as illustrated by a demonstration site.

Table 46. Data from a national repricing company helps substantiate the potential cost-savings from use of ABC codes to support clean EDI claims.

Hypothesis: The experience of a repricing company provides evidence that expanded definitions associated with ABC codes will generate significant system cost-savings.

Method: Review the claims processing patterns of a national repricing company.
Calculate cost-savings achievable through elimination of attachments.
Nationalize the cost-savings and compare them to the above model.

Assumptions: Equal distribution of "direct bill" IHC claims across EDI and paper.
All "direct bill" IHC claims are complex.
75% of "direct bill" IHC claims require attachments.
3.0 billion practitioner claims are processed in the U.S. per year.
245 million $_{\text{insured lives}} \times 12$ $_{\text{practitioner claims/year/insured}} = 2.95$ billion $_{\text{claims/year}}$

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	789.6 million claims per year are from "direct bill" IHCPs 872,200 $_{\text{IHCPs}}$ x 8 $_{\text{claims/day}}$ x 246 $_{\text{workdays/year}}$ x .46 $_{\text{insurer paid}}$ = 789,585,216 $_{\text{IHCPs claims}}$
Data:	One SBU in the company processed 11,808 inbound EDI transactions (837P) a month. The SBU processed 63,375 paper-based transactions a month. Claims attachments added approximately $11 per claim to EDI claims. Claims attachments added approximately $18 per claim to paper claims. 14.59% of claims were from "direct bill" IHCPs.
Calculation:	(11,808 $_{\text{EDI}}$ + 63,375 $_{\text{paper}}$) x 14.59% $_{\text{IHCP claims}}$ = 10,969 "direct bill" IHC claims ($11 $_{\text{EDI attachment cost}}$ + $18 $_{\text{paper attachment cost}}$) / 2 = $14.50 average savings per claim per eliminated attachment 10,969 $_{\text{IHC claims}}$ x .75$_{\text{attachment probability}}$ x .50 $_{\text{elimination of attachment from ABC codes}}$ x $14.50 $_{\text{savings through eliminated attachments}}$ = $59,645 savings through eliminated attachments on "direct bill" IHC claims 789,585,216 $_{\text{IHC claims/year}}$ x 59,645 $_{\text{savings}}$ / 10,969 $_{\text{IHC claims in demonstration site}}$ = $4.3 billion in nationalized savings from eliminated attachments on "direct bill" IHC claims
Conclusion:	The experience of the repricing company suggests potential national cost-savings of $4.3 billion nationally from eliminated attachments on "direct bill" IHC claims.[178]

Nationalizing the experience of this repricing company results in a number even higher that the cost-benefit model, so the $3.26 billion figure may be considered conservative.

Within EDI-Related Savings, Reduced Communications Will Save More Than $7.8 Billion

The lack of complete, accurate and precise HIPAA codes for IHC results in significant productivity losses and costs as practitioners, provider organizations, clearinghouses and health plans are forced to communicate directly to clarify the circumstances surrounding care delivery.

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Table 47. Communications to support "direct bill" IHC claims can add $7.50 or more in system costs per claim. To avoid these costs, "direct bill" IHCPs may opt for MD oversight and administrative fees.

Hypothesis:	Eliminating communications associated with "direct bill" IHC claims (made possible by deployment of ABC codes) will generate significant system cost-savings.
Method:	Estimate the number of "direct bill" IHC claims. Estimate the number of communications per claim. Estimate the cost per communication. Estimate the number of communications eliminated through use of ABC codes.
Assumptions:	"Direct bill" IHCPs earn $75/hour, including benefits.[179] Administrative personnel earn $15/hour, including benefits.[180] The cost per minute of communication is $.75 per party (($75 + $15) / 2) / 60 $_{\text{minutes/hour}}$ 789.6 million claims per year are from "direct bill" IHCPs 872,200 $_{\text{IHCPs}}$ x 8 $_{\text{claims/day}}$ x 246 $_{\text{workdays/year}}$ x .46 $_{\text{insurer paid}}$ = 789,585,216 $_{\text{IHCPs claims}}$ 25% of these require direct communications totaling 10 minutes (5 minutes for the IHCP and 5 minutes for the administrator). 75% of these communications could have been avoided through use of ABC codes.
Data:	N/A
Calculation:	789.6 million $_{\text{IHC claims}}$ x 25% $_{\text{requiring communication}}$ x $7.50 $_{\text{communication cost}}$ x 75% $_{\text{avoided via ABC codes}}$ = $1.1 billion in savings through use of ABC codes to avoid claims communications required to support "direct bill" IHC claims
Conclusion:	Use of ABC codes to eliminate the need for communications around "direct bill" IHC claims will generate system cost-savings of an estimated $1.1 billion a year.

Further costs can be incurred between the practitioners themselves. Many IHCPs rely on MDs for administrative oversight to keep claims from being kicked into manual adjudication processes. This is because a paper insurance claim typically takes about 45 days for reimbursement versus 14 days or less for an electronic claim.[181] If the claim is viewed as complex (which a majority of claims originating from IHCPs are), that time can more than double.[182]

The reliance on MDs for administrative oversight creates the need for communications between the practitioners, as well as between their respective administrative personnel.

To be conservative, Alternative Link assumed an average of one three-minute communication per claim, with two parties involved, i.e., six minutes per claim and 5% of each work hour per practitioner.

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Table 48. Eliminating communications between RNs and supervising MDs using ABC codes generates system savings of $6.67 billion a year.

Hypothesis:	Even for a single IHC category, eliminating communications between the supervising MD and the IHCP (made possible by ABC codes) will generate significant system cost-savings.
Method:	Choose an IHCP category: RNs Estimate the number of patient encounters that will be MD-supervised. Estimate the communication cost per supervised encounter. Estimate the communication costs eliminated through use of ABC codes.
Assumptions:	RNs earn $35/hour, including benefits.[183] MDs earn $105/hour, including benefits.[184] The cost per minute of communication is $1.17 per party. (($35 + $105) / 2) / 60 $_{\text{minutes/hour}}$ 85% of nursing encounters are insurer paid. 245,809,777 $_{\text{insured}}$ / 290,809,777 $_{\text{total population}}$ 95% of these visits are MD supervised 25% of these require direct communications totaling 6 minutes (3 minutes for the RN and 3 minutes for MD). 75% of these communications could have been avoided through use of ABC codes (e.g., in bedside monitors that auto-load selected ABC codes and corresponding care descriptions into patients' electronic medical records).
Data:	2.0 million RNs 10 patient encounters per RN per day
Calculation:	2.0 million $_{\text{RNs}}$ x 246 $_{\text{days/year}}$ x 10 encounters/day x 85% $_{\text{insurer paid}}$ x 95% $_{\text{MD supervised}}$ x 25% $_{\text{requiring communication}}$ x 3 $_{\text{minute communication}}$ x 1.17_{\text{/minute}}$ x 2 $_{\text{parties}}$ x 75% $_{\text{avoided through ABC codes}}$ = $6.67 billion in savings from avoided RN to MD communications around RN patient encounters
Conclusion:	Use of ABC codes to eliminate the need for communications between RNs and supervising MDs is $6.67 billion a year. Eliminating communications among RNs and LPNs/LVNs would generate additional system savings. The use of ABC codes to automatically document nursing care would generate additional savings by 1) reducing medical errors and documentation costs and 2) improving patient charting.

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Use of ABC codes would also reduce the administrative burden on RNs, improve RN productivity and help alleviate the nursing shortage.

The cost-benefit of this category of savings is beyond the scope of this report.

Practitioner to practitioner communications not only create an administrative burden for caregivers, but may also compromise the quality of care by distracting them from important time with patients.

Administrative Efficiencies in Areas Other Than EDI Will Save More Than $3.1 Billion

Precise coding creates cost-savings both before and after claims are generated and adjudicated. For example, use of ABC codes in conjunction with CPT and HCPCS II codes on superbills or patient encounter forms saves billing administrators from trying to find an acceptable HCPCS code for billing without crossing the line into fraud and abuse. If health plans do not yet accept ABC codes (a situation encountered by numerous practitioners during the demonstration program), the ABC codes can be crosswalked to HCPCS codes on the superbill. The precision that ABC codes add to patient encounter forms can be useful as an adjunct to medical record keeping and in justifying claims that get questioned by health plans.

Table 49. ABC codes extend the benefits of HIPAA to health practitioners other than MDs. Administrative cost-savings are estimated at $3.1 billion.

Hypothesis:	ABC codes create clinical practice management efficiencies beyond those directly related to HIPAA and electronic commerce.
Method:	Identify the clinical practice cost savings predicted for each MD as a result of HIPAA. Discount for EDI-related savings previously noted. Discount for practice volume differences between MDs and "direct bill" IHCPs.
Assumptions:	A total of a 50% discount of the predicted MD practice savings associated with HIPAA should be applied to "direct bill" IHCPs. 25% of the clinical practice cost savings are assignable to EDI transactions between MDs and insurers. 25% of the clinical practice cost savings are variable costs driven by incremental MD patient volume over IHCP patient volume.
Data:	The American Association of Family Practitioners reported that HIPAA transactions and code sets save each practitioner approximately $7,200[185] in administrative costs per year.
Calculation:	$7,200 $_{\text{MD savings from HIPAA}}$ x (100% - 25% $_{\text{EDI discount}}$ – 25% $_{\text{IHCP volume discount}}$) = $3.1 billion in clinical practice savings for "direct bill" IHCPs

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Conclusion:	"Direct bill" IHCPs will save $3.1 billion a year in clinical practice management savings beyond those related to EDI.

Alternative Link and NaviMedix[186] co-developed models of administrative and medical cost-savings made possible by deployment of ABC codes. The models addressed use of ABC codes with and without accompanying HCIT business process reengineering. The most basic administrative cost-savings model revealed a fourfold cost-savings made possible by deploying ABC codes.

For claims submitted with HCPCS codes only, NaviMedix documented adjudication costs of
- $5-7 per claim for ***clean paper claims*** in semi-automated adjudication processes, and
- $26-30 per claim for ***complex paper claims*** in semi-automated claims adjudication processes.

Complex claims required extra manual steps such as clarifying the medical necessity of care coded with a ***not otherwise classified*** code or verifying legal scope of practice for IHCPs.

Comparing NaviMedix data to the literature and reports of other demonstration sites, Alternative Link assigned claims adjudication costs as follows:
- Clean paper claim (roundtrip): $5.00
- Complex paper claim (roundtrip): $23.00
- Clean EDI transaction (roundtrip): $1.00
- Complex EDI transaction (roundtrip): $12.00

Table 50. The cost-savings associated with conversion of complex paper claims to clean paper claims (made possible through use of ABC codes) justifies deployment of ABC codes even without EDI.

Hypothesis:	ABC codes generate significant system cost-savings in manual and partially automated business processes (i.e., even without the benefits of EDI).
Method:	Review the savings associated with a small demonstration site that involved a health plan, TPA and PPO that still relied on paper-claims.
Assumptions:	Conversation of complex paper claims to clean paper claims generates $18 in savings. IHC claims without ABC codes are necessarily complex. IHC claims with ABC codes are clean.
Data:	The small PPO generated 4,275 IHC claims billed with ABC codes over three years.
Calculations:	$4{,}275_{\text{ IHC claims}} \times \$18_{\text{ ABC savings per claim}}$ = $76,950 in business process improvements savings.

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Conclusion:	The use of ABC codes resulted in the elimination of extra manual steps in partially automated claims adjudication and saved $76,950 for this health system.

Use of Cost-Effective IHC Will Save More Than $15 Billion

A significant portion of the cost-savings achievable through deployment of ABC codes results from displacement of high cost and/or high risk conventional care with lower cost and/or lower risk IHC interventions. This controversial area of economic study has been addressed by numerous researchers, but most represent SIGs.

Table 51. Use of cost-effective and noninvasive IHC as a complement or alternative to MD care (especially drug and surgical interventions) can save billions of healthcare dollars each year and reduce patient risk.

Hypothesis:	Use of IHC made possible by ABC codes displaces conventional care and counters medical cost escalation.
Method:	Estimate the Medicare Advantage savings associated with use of ABC codes.
Assumption:	Medicare Advantage has a slight net gain on IHC delivered through Bridges in Medicine that substantiates the significant program expansion.
Data:	872,200 "direct bill" IHCPs nationwide 230,000 APNs nationwide 28 Bridges in Medicine IHCPs and non-APNs with $5,357 in new revenues each Medicare Advantage medical cost CAGR of 13%[187]
Calculations:	$872{,}200_{\text{IHCPs nationwide}} - 230{,}000_{\text{APN}} \times \$5{,}357_{\text{2004 BIM IHCP incremental revenues}}$ = $3.44 billion in medical cost displacement and countering of medical cost escalation
Conclusion:	The nationalized medical cost-savings achieved by selectively authorizing cost-effective care delivered by 642,200 "direct bill" IHCPs and non-APNs would be $3.44 billion.

Alternative Link has surveyed the cost-effectiveness studies of conventional, complementary and alternative care, as well as MDs and IHCPs.

Compelling evidence exists to support savings of tens of billions of dollars a year through the systematic identification and promotion of best practices across care types and caregivers.

The need for such evidence-based care is widely recognized.[188]

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Table 52. America's Health Insurance Plans supports consumer choice and evidence-based healthcare.

"…times call for the nation to make a renewed commitment to meet the needs and expectations of health care consumers regardless of health, socioeconomic status, location or other circumstances.

… the American people are ready to embrace bold measures that directly address the root causes of diminished access, inconsistent quality, and accelerating costs in the U.S. health care system. The public is eager to move beyond one-size-fits-all solutions and consider an integrated—rather than a "thinking in silos"—approach that recognizes the linkages among quality, access, and cost initiatives.

…a concerted nationwide effort will yield multiple dividends for Americans. The economy will benefit by simultaneously constraining costs, extending coverage to the uninsured, and improving care. A strong emphasis on quality initiatives can redirect resources to help cover the uninsured and, similarly, measures to expand access can improve the affordability of health care.

…the health care system of today has the capabilities necessary to transform coverage and care tomorrow in ways that will streamline and strengthen the system rather than merely burdening it with added complexity and costs.

…that a system that advances access to high quality, affordable health care coverage for all will significantly improve health care outcomes and ultimately the health of Americans.

…stakeholders, public and private… (need to work together) in advocating and advancing a series of broad-ranging, inter-linking initiatives:

QUALITY – Make evidence-based medicine the standard for health care, and advance quality and transparency to improve outcomes, eliminate errors, reduce costs, and help consumers make informed health care choices.

ACCESS – Use targeted strategies to give all Americans access through public and private coverage and through support for the public health infrastructure.

AFFORDABILITY – Maximize the cost-savings that can be achieved through improvements in access and quality and, at the same time, take additional steps to make health care more affordable through regulatory, legal, and other reforms.

- AHIP Board of Directors, 2004[189]

For the purpose of this report and the demonstration of the cost-benefit of ABC codes, Alternative Link focused on APNs, known to provide care in medically underserved areas of the U.S.

Table 53. $11.6 billion may be saved by using cost-effective APN services for routine E&M/assessment visits.

Hypothesis:	Use of cost-effective APN assessments (made possible by use of ABC codes) in lieu of MD evaluation and management (E&M) care will generate substantial system cost-saving.
Method:	Identify the cost of MD care in routine E&M visits. Derive from the literature the cost-savings associated with APN care. Determine the percentage of MD care that can be replaced with APN care without compromising the quality of care. Calculate the cost-savings.

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Assumptions:	75% of CPT code 99213 interventions are currently performed by MDs. 75% of CPT code 99213 interventions performed by MDs could be performed by APNs without MD supervision.[190] The total cost of care associated with delivery of primary and preventive care by APN care offers 20% in savings over MD care, including care delivered under CPT code 99213. [191] [192] Medicare represents 50% of federal expenditures on healthcare.
Data:	230,000 APNs nationwide National allowed charges for CPT Code 99213 for 2001 were $ 4,875,761,305[193] All nurse practitioners are allowed to independently bill for services in all states.[194] $ 4,875,761,305 in allowed charges for CPT code 99213 in Medicare Part B nationwide.[195] Federal programs pay 29.3% of national healthcare expenditures.
Calculations:	$4,875,761,305 x 75% $_{MDs}$ x 75% $_{APNs}$ x .20 $_{APN\ efficiency\ factor}$ = $548,523,147 in savings for Medicare Part B ($548,523,147 $_{APN\ savings\ for\ Medicare}$) / (29.3% $_{Federal\ expenditures}$ x 50% $_{Medicare\ expenditures}$) = $3.74 billion in savings from use of APNs in patient assessments in lieu of MDs in routine E&M visits
Conclusion:	Use of cost-effective APN care (made possible by use of ABC codes) in the 75% of CPT code 99213 E&M visits considered routine would save Medicare Part B $546 million and would save the nation $3.74 billion.
Note:	This figure is expanded to address top E&M/assessment codes beyond CPT code 99213 in Table 56. $11.59 billion in national cost-savings is derived from top E&M codes and use of APN assessments in lieu of non-complex MD E&M visits, made possible by ABC codes.

Alternative Link considers these figures conservative and leaves further study of this controversial outcome of ABC codes to other researchers.

Improved Relative Values Will Save More Than $7.7 Billion

In the few areas in which HCPCS addressed IHC interventions, the granularity of ABC codes tends to be superior. Where crosswalks exist, the relationship between *not otherwise classified* HCPCS codes and ABC codes is one to many.

Precision in the ABC code set supports development of rational relative values that help to ensure that contracts and payment are equitable—or, at least, rational.

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Table 54. Use of RVUs or RBRVS units for precise ABC codes saves money over typical allowables for less granular HCPCS codes.

Hypothesis:	Use of RBRVS units associated with precise ABC codes in lieu of UCR or RBRVS units associated with less granular CPT codes will result in considerable system savings.
Method:	Focus on a CPT code in the Medicare Part B Top 200 list that has a one-to-many mapping with ABC codes. Focus on an ABC code that reflects an intervention known to have high utilization. Estimate the percentage of Medicare Part B service volume billed using the CPT code that could have been more precisely represented by the ABC code. Calculate the difference in theoretical payment levels that would have resulted from billing that percentage using the CPT code versus the ABC code. Discount for the difference between Medicare Part B theoretical allowables and actual allowables. Nationalize the findings for the single code.
Assumptions:	If this code were used to bill exercise therapy associated with joint mobility, Assuming 1% of the estimated 14.3 million national claims[196] with this code were associated with improving joint mobility, the national savings would be approximately $948,000. Medicare accounts for 50% of Federal healthcare expenditures
Data:	$358,175,868 in actual allowed charges for CPT 97110 under Medicare Part B 14,272,312 allowed services for CPT 97110 under Medicare Part B $25.10 average allowed charges for CPT 97110 under Medicare Part B[197] CPT 97110 RBRVS of .77 in 2004 ABC BBAAF RBRVS of .53 in 2004 Medicare/Medicaid 2004 Conversion Factor of $36.1192 The Federal government pays 29.3% of national healthcare expenditures.
Calculations:	$(14{,}272{,}312_{\text{CPT 97110 in Medicare Part B}} \times .77_{\text{RBRVS CPT}} \times \$36.1192_{\text{CF}})$ = $396,938,459 in theoretically allowed charges under Medicare Part B $(\$396{,}938{,}459_{\text{theoretical}} - \$358{,}175{,}868_{\text{actual}}) / \$396{,}938{,}459_{\text{theoretical}}$ = 9.77% Discount Factor for Actual Allowables $(14{,}272{,}312_{\text{CPT 97110 in Medicare Part B}} \times .77_{\text{RBRVS CPT}} \times \$36.1192_{\text{CF}} \times 1\%_{\text{joint mobility}})$ = $3,969,385 in theoretical CPT charges for joint mobility $(14{,}272{,}312_{\text{ABC BBAAF in Medicare Part B}} \times .53_{\text{RBRVS ABC}} \times \$36.1192_{\text{CF}} \times 1\%_{\text{joint-mobility}})$

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$2,732,174 in theoretically allowed ABC coding charges under Medicare Part B

($3,969,385 CPT theoretical Medicare Part B - $2.73 million ABC theoretical Medicare Part B)
= $1,237,211 in theoretical Medicare Part B savings

$1,237,211 theoretical Medicare Part B savings x (100-9.77% Discount Factor for Actual Allowables)
= $849,586 in actual potential Medicare Part B savings

= $849,586 Medicare Part B savings / 14.65% national HC expenditures attributable to Medicare
= $5,799,214 in savings from use of ABC code BBAAF instead of CPT code 99110 for an estimated 1% of charges nationwide associated with joint-mobility

Conclusion: Medicare could save $849,586 annually through use of ABC code BBAAF instead of CPT code 99110 in the 1% of claims that reflect joint mobility treatments.

The nation could save $5.8 million annually through use of even one precise ABC code in place of a less granular CPT code.

As codes are developed, RVSI uses its proprietary methodology (an experience-based system that employs survey consensus and was derived from the methodology used for "Relative Values for Physicians") to establish RVUs for these interventions.

The resulting RVUs reflect the resources associated with each practitioner intervention based on time, skill, risk to patient, risk to practitioner and severity of the patient condition.

These RVUs are then crosswalked to RBRVS units to support organizations that use the Medicare/Medicaid relative value model.

Among the professions that benefit from precise RVUs are the nursing professions. In developing the ABC code set, Alternative Link incorporated official nursing terminologies. The Company has continued to work with nursing associations to ensure ABC terminology and codes remain current. As a result, the RVUs reflected by the codes for nursing provide a rational basis for fee development and compensation.

In many cases, the RVU that corresponds to an ABC code for an IHC intervention is lower than the RVU that corresponds to a less granular HCPCS code for a similar type of intervention. This difference can mean substantial cost-savings for the U.S. healthcare system.

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Table 55. ABC codes reflect more than a thousand nursing interventions to support cost-effective nursing practices.

Over one thousand ABC codes reflect nursing care.[198]

HCPCS offers relatively few nursing codes, since CPT codes originate from an MD trade association and HCPCS II codes are developed to support Medicare and Medicaid payment policies.[199]

ABC codes for nursing interventions are derived from the official nursing terminologies of the Nursing Intervention Classification Scheme (NIC), the Omaha System Intervention Scheme (Omaha), the Home Health Care Classification System (HHCC), the National Association of Clinical Nurse Specialists and other SMEs within the field of nursing informatics.

For example, APNs deliver care similar to the care reflected by CPT code (99213). However, this code describes MD actions, not nursing actions:

> ***"Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:***
> - *An expanded problem focused history;*
> - *An expanded problem focused examination;*
> - *Medical decision making of low complexity."*
>
> *Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.* [200]

This code reflects the development of medical diagnoses and medical treatment plans. It is also used by MDs who oversee the evaluation and management of patient care by IHCPs. The patients' presenting problems are typically of low to moderate severity. Caregivers usually spend less than 15-minutes face-to-face with the patient and/or family.[201]

CPT code 99213 is the most commonly billed code in the U.S.[202]

The potential medical cost-savings associated with use of ABC codes can be addressed by reconsidering the earlier example of use of APN assessments in lieu of non-complex MD E&M care.

All APNs are allowed to independently bill for this care in all states.[203]

The National Association of Clinical Nurse Specialists and Dorothy Jones, PhD, CNS, NP (a nursing terminology expert) submitted terminology to support development of ABC codes that reflected relevant nursing diagnoses and interventions.

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The resulting ABC code was described as follows:

> *Hierarchic description:* ***"Nurse detailed existing in-office 15 minutes, Existing client in-office with nursing diagnosis, Client assessment, Clinical practice management"***
>
> *Expanded definition: Assessing and/or managing an existing client using nursing diagnoses in a simple, 15-minute, in-office meeting. Use this code to describe advanced nursing care without physician oversight. The client may or may not have a medical diagnosis. Service is billed in 15-minute increments.*

Table 56. The relative values associated with ABC codes accommodate the differences in health practitioner efficiencies because the codes more precisely reflect their actual practices. For use of APNs alone in top E&M/assessment visits, this adds $7.7 billion in system savings.

Hypothesis:	Because ABC codes more precisely reflect care delivered by IHCPs, the associated relative values reflect IHCP efficiencies and will generate system efficiencies over less granular MD relative values.
Method:	Revisit the use of APN assessments in lieu of non-complex MD E&M care. (Table 53) Identify the difference in relative values between the corresponding CPT code and ABC code. Recalculate the system cost-savings based on differences in relative values assigned to the codes, rather than differences in clinician efficiencies.
Assumption:	Medicare accounts for 50% of Federal healthcare expenditures
Data:	The MD CPT code is 99213. The CPT RBRVS is 1.41. The APN ABC code is ACFAF. The ABC RBRVS is .94.[204] $4,875,761,305 in actual allowed charges for CPT 99213 under Medicare Part B 100,205,122 actual allowed services for CPT 99213 under Medicare Part B $48.66 average allowed charges for CPT 99213 under Medicare Part B[205] Medicare/Medicaid 2004 Conversion Factor of $36.1192 The Federal government pays 29.3% of national healthcare expenditures. The theoretical value of CPT 99213 based on the RBRVS units is $50.93.
Calculations:	(100,205,122 $_{\text{CPT 97213 in Medicare Part B}}$ x 1.41 $_{\text{RBRVS CPT}}$ x $36.1192 $_{\text{CF}}$) = ($5,103,253,668 in theoretically allowed charges under Medicare Part B ($5,103,253,668 $_{\text{theoretical}}$ - $4,875,761,305 $_{\text{actual}}$) / ($5,103,253,668 $_{\text{theoretical}}$ = 4.45% Discount Factor for Actual Allowables

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(100,205,122 $_{\text{CPT 99213 Medicare}}$ x 1.41 $_{\text{RBRVS CPT}}$ x $36.1192 $_{\text{CF}}$ x 75% $_{\text{MDs}}$ x 75% $_{\text{APNs}}$)
= $2,870,580,188 in theoretical CPT charges for theoretical displaceable MD allowables for 99213

(100,205,122 $_{\text{ABC ACFAF Medicare Part B}}$ x .94 $_{\text{RBRVS ABC}}$ x $36.1192 $_{\text{CF}}$ x 75% $_{\text{MDs}}$ x 75% $_{\text{APNs}}$)

= $1,913,720,125 in theoretical ABC charges for displacing APN care under Medicare Part B

($2,870,580,188 $_{\text{CPT theoretical Medicare Part B}}$ - $1,913,720,125 $_{\text{ABC theoretical Medicare Part B}}$)
= $956,860,063 in theoretical Medicare Part B savings

$956,860,063 $_{\text{theoretical Medicare Part B savings}}$ x (100-4.45% $_{\text{Discount Factor for Actual Allowables}}$)
= $914,246,482 in actual potential Medicare Part B savings

= $914,246,482 in actual potential Medicare Part B savings
= ($914,246,482 $_{\text{Medicare Part B savings}}$ / 14.65% $_{\text{national HC expenditures attributable to Medicare}}$)

= $6,240,590,320 in savings from use of the ABC code ACFAF RBRVS instead of CPT code 99213 RBRVS

Conclusion 1: Medicare could save $914.2 million through use of ABC code ACFAF instead of CPT code 99213 in the 75% of MD E&M visits that could be performed by APNs, as APN assessments, but this includes savings attributable to both ABC RBRVS precision and clinical displacement. The nation could save $6.24 billion through use of ABC code ACFAF instead of CPT code 99213 in the 75% of MD E&M visits that could be performed as assessments by APNs, but this includes savings attributable to both ABC RBRVS precision and clinical displacement.

New Data: The medical cost savings from APNs noted in Table 53 was $3.74 billion.

Calculation 2: $6.24 billion $_{\text{ABC RBRVS savings}}$ - $3.74 billion $_{\text{APN medical cost savings}}$
= $2.5 billion in savings assignable to the precision of ABC relative values

Conclusion 2: The incremental benefit assignable to the precision of ABC code relative values (versus the clinician efficiencies reported in Table 53) is $2.5 billion.

Data 2: 992_ _ E&M codes among top 15 CPT codes in Medicare Part B, excluding CPT code 99213, have allowed charges of $10,212,524,970.

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Calculation 3: ($914,246,482 Medicare Part B ABC RBRVS savings x 40% ABC RVRBS [$2.5 B/$6.24 B])
/ ($4,875,761,305 Medicare CPT allowable)
= 7.5% savings through ABC RBRVS (not including caregiver efficiencies)

($914,246,482 Medicare Part B ABC RBRVS savings x 60% ABC caregiver efficiencies [$3.74 B/$6.24 B])
/ ($4,875,761,305 Medicare CPT allowable)
= 11.25% savings through ABC clinical displacement efficiencies (not including ABC RBRVS efficiencies)

= 18.75% in combined efficiencies resulting from clinical displacement and ABC RBRVS

$10,212,524,970 non-99213 + $4,875,981,237 ACFAF~99213
= $15,088,286,275 in total Medicare allowables for top E&M codes

$15,088,286,275 Medicare top E&M x 7.5% ABC RBRVS savings
= $1,131,637,965 in Medicare savings associated with top E&M codes and ABC codes' RBVS functionality

$15,088,286,275 Medicare top E&M x 11.25% ABC clinical displacement savings
= $1,697,456,948 in Medicare savings associated with top E&M codes and clinical displacement made possible by ABC codes

= $1,131,637,965 Medicare ABC RBRVS + $1,697,456,948 Medicare clinical displacement
= $2,829,094,914 in Medicare savings associated with top E&M codes and both clinical displacement and RBRVS functionality associated with ABC codes

$1,131,637,965 Medicare ABC RBRVS / 14.65% national HC expenditures attributable to Medicare
= $7,724,491,232 in national savings associated with top E&M codes and ABC codes' RBRVS functionality

$1,697,456,948 Medicare clinical displacement / 14.65% national HC expenditures attributable to Medicare
= $11,586,736,848 in national savings associated use of APN assessments in lieu of non-complex MD E&M care, made possible by ABC codes. (Noted in Table 53.)

$2,829,094,914Medicare Part B savings / 14.65% national HC expenditures attributable to Medicare)
= $19,311,228,080 in national savings associated with top E&M codes, ABC codes' RBRVS functionality and use of APN assessments in lieu of non-complex MD E&M care, made possible by ABC codes.

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For some diagnoses, IHCPs can provide equal or better outcomes than their MD counterparts. If the associated IHCP claims use HCPCS codes, the cost-effectiveness of their care may not become apparent. However, if ABC codes are used, a clear difference in both economic and health outcomes will become apparent so that best practices can be identified and made the standard approach to care.

Table 57. MediMerge used a combination of ABC, CPT and HCPCS II codes to develop a Guideway® for treatment of back pain among employees of a Fortune 200 company. Claims data confirmed the ability of this and other Guideways to deliver more than 8% in benefit cost-savings in the first year.

In designing a back pain Guideway® for a Fortune 200 company, MediMerge noted CPT codes either did not exist for, or did not reflect with sufficient granularity, all of the cost-effective interventions that were available and recommended.

ABC codes reflected many of the overlooked areas of care, especially those related to CAM.

In MediMerge's "Comparison of Data Capture for Back Pain Disorders," the company identified the following fields (that were essential to health plan cost-savings) as being better supported by ABC codes:[206]

1. Massage, Bodywork and Somatic Education
2. Clinical Nutrition
3. Acupuncture and Oriental Medicine
4. Homeopathy
5. Christian Science

This code set granularity supports development of more complete, accurate and precise relative values for each intervention.

Practitioner Identifiers and Elimination of Unnecessary Claim Forms Will Save $478.6 Million

The practitioner identifier used with ABC codes supports immediate savings of more than $478.6 million through the eliminated of separate claims from IHCPs with multiple credentials.

Since each 5-character ABC code listed on an insurance claim form has a corresponding 2-character modifier that indicates the practitioner type, a practitioner with multiple credentials can submit a single insurance claim with a broad range of integrative health interventions.

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Table 58. The modifier used with the ABC code set identifies the type of caregiver. This supports contracting, credentialing, claims volume reductions and outcomes research.

Example:	A ***nurse practitioner*** who is also a ***registered dietician*** and an ***acupuncturist*** can use ABC codes to submit a single CMS-1500 form for the following interventions:
	BFBAI-***1H***: Supporting a client in maintain his or her optimal body fat percentage and/or weight. Service is billed in 15-minute increments.
	BFAAJ-***1X***: Teaching clients in group setting a holistic approach to diet modification. Service is billed in 15-minute increments per client.
	CACAE-***1C***: Applying heat to acupoints by using moxa or another incandescent material without causing pain or burning. Service is billed in 15-minute increments.

Without ABC codes—and with provider taxonomy codes still not fully deployed under HIPAA—as many as three CMS-1500 forms or 837P (healthcare claim: profession) transactions would be submitted—each representing a different practitioner type. The lack of corresponding relative values, legal scope of practice information and training requirements would likely result in requirements for attachments and manual review of all three insurance claims

Table 59. Practitioner identifiers offer cost-savings of approximately $478.6 million, due to avoided claims, when used by "direct bill" IHCPs with multiple credentials.

Hypothesis:	Consistent use of code modifiers to identify caregivers (functionality associated with ABC codes) will generate substantial system savings.
Method:	Quantify the cost of the current approach to identifying practitioner type. Quantify the savings associated with using practitioner identifiers as code modifiers.
Assumptions:	5% of IHCPs have multiple credentials.[207] Each "direct bill" IHCP sees 8 patients per workday. These IHCPs submit claims to health plans for 46% of patient visits.[208] [209] [210] These IHCPs file 95% of claims via paper. All multi-disciplinary claims are complex claims. A typical claim has 2.3 coded line items. Cost-savings of converting from complex to clean EDI is $11. Cost-savings of converting from complex paper to clean EDI is $22.
Data:	872,200 "direct bill" IHCPs
Calculations:	$((872{,}200_{\text{IHCPs}} \times .05_{\text{multi-disciplinary}} \times 8_{\text{visits/day}} \times .46_{\text{billed to health plans}}$ $\times (365_{\text{days/year}} - 104_{\text{weekend days}} - 15_{\text{holidays/vacation days}}))$ = 39,479,261 claims/year from multi-credentialed IHCPs

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	$39{,}479{,}261_{\text{claims/year}}$ - $(39{,}479{,}261_{\text{claims/year}})/ (2.3_{\text{line items/claim}})$ = 22,314,365 avoided claims from multi-disciplinary IHCPs $((22{,}314{,}365_{\text{avoided claims}} \times .95_{\text{paper}}) \times (\$22_{\text{high estimate for paper}}))$ $+ ((22{,}314{,}365 \times .05_{\text{EDI}}) \times (\$11_{\text{high estimate for EDI}}))$ = $478,643,125 in savings from avoided claims from multi-disciplinary IHCPs
Conclusion:	Practitioner identifiers offer cost-savings of approximately $478.6 million, due to avoided claims, when used by "direct bill" IHCPs with multiple credentials

Reduced MD Administrative Fees Will Save More Than $8.6 Billion

An estimated 872,200 IHCPs have the legal right to bill health plans directly for delivered care.

However, several factors complicate the adjudication of their insurance claims and make direct billing less cost-effective than routing claims through MDs, including (but not limited to) the following:

- Lack of precision in the HIPAA code sets, so the nature of delivered care is unclear
- Missing or imprecise relative values, so the charge is questioned
- Lack of information on the medical necessity and cost-effectiveness of care, so the claim is pended, the fee reduced or the number of visits capped
- A need for attachments and manual review steps that delayed payments or resulted in denials

When these claims are processed through an MD to accelerate payment, the MD typically adds an administrative service fee to the charges and bills using an accepted CPT code for physicians. The administrative fee can be substantial, and the cost-benefit of the MD oversight is not known.

Table 60. Avoidance of MD administrative fees (made possible by direct billing of insurers by IHCPs using ABC codes) generates more than $8.61 billion in savings.

Hypothesis:	Supporting direct billing by legally qualified IHCPs will eliminate administrative fees charged by supervising MDs and generate substantial system savings.
Method:	Estimate the portion of IHCP claims billed through MDs. Identify the total number of claims that could be direct billed by IHCPs. Identify a typical MD administrative fee.
Assumptions:	50% of IHC claims that could be direct billed are billed through MDs to minimize administrative burdens, payment delays and payment denials. 75% of claims billed through an MD could have been direct billed without administrative burdens, payment delays and payment denials by using ABC codes. A typical supervising MD increases the cost of an IHC claim by $15 When ABC codes are fully deployed for all IHCPs, 97% of IHCPs will be able to direct bill.

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Data:	872,200 "direct bill" IHCPs 8 visits a day to each IHCP 46% of patient encounters billed to insurers
Calculations:	872,200 $_{\text{IHCPs}}$ x 8 $_{\text{visits/day}}$ x 246 $_{\text{workdays}}$ x 46% $_{\text{billed to insurers}}$ x 75% $_{\text{MD-billed}}$ x $15 $_{\text{administrative fee}}$ x 97% $_{\text{billable w/ABC codes}}$ = $8,616,348,670 in savings by eliminating MD administrative fees on IHCP care
Conclusion:	By eliminating physician administrative fees on IHCPs, insurers can save an estimated $8.61 billion.

ABC codes provide sufficient precision to overcome questions about the nature of delivered care and, in many cases, the need for attachments.

Corresponding data elements—such as practitioner identifiers, relative values, legal scope of practice information and training standards[211] and clinical efficacy and cost-effectiveness information[212]—can overcome the remaining claims adjudication challenges.

Table 61. Eliminating the MD administrative fee associated with one category of IHC, such as APN care, can save $1.42 billion annually.

Hypothesis:	Direct insurance billing (made possible by ABC codes) of even a small percentage IHCP patient encounters eliminates substantial MD administrative fees and generates substantial system savings.
Method:	Use APNs as an example. Estimate the percentage of patient encounters for which APNs direct bill insurers, bill through MDs or direct bill patients. Calculate the savings associated with more direct billing of insurers by APNs.
Assumptions:	10% of APN encounters are direct-billed to insurers. 10% of APN encounters are direct-billed to patients. Each APN sees 10 patients per day. APNs work 246 days per year. 25% of APN encounters are non-facility related (i.e., ambulatory). 85% of these encounters are covered by insurance. 80% of these ambulatory APN encounters are MD-billed to insurers. MDs charge a $15 administrative fee on the claims they bill on behalf of IHCPs.
Data:	230,000 APNs

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Calculations:	230,000 $_{APNs}$ x 10 $_{visits/day}$ x 246 $_{days/year}$ x 25% $_{ambulatory}$ x 85% $_{coverage}$ x 80% $_{MD\text{-}billed}$ x \$15 $_{administrative\ fee}$ = \$1,442,790,000 in potential savings through elimination of the administrative fee associated with MD billing of ambulatory APN patient encounters
Conclusion:	Eliminating the MD administrative fee on ambulatory APN patient encounters billed to insurers (made possible by ABC codes) will generate \$1.42 billion in system savings.

Even on a small scale the savings associated with avoidance of administrative fees can be substantial.

This was noted in a demonstration site, where the cost-savings that could have been achieved by eliminating the administrative fees charged by a single physician was more than half a million dollars a year.

Table 62. Insufficient coding for IHCPs positions supervising MDs to earn ¼ of their incomes and $8.6 billion nationally in administrative fees for IHCP oversight and billing even when the cost-benefit of those activities has not been evaluated.

Hypothesis:	Insufficient coding for IHCPs positions MDs to secure administrative fees for IHCP oversight, at a substantial cost to the system.
Method:	Estimate the revenues a supervising MD could earn by overseeing, and billing on behalf of, IHCPs. Nationalize these figures.
Assumptions:	575,000 MDs are active. 872,200 "direct bill" IHCPs are active. MDs who supervise IHCPs oversee 1.52 IHCPs who could otherwise direct bill. One-third of MDs supervise IHCPs. A typical IHCP charge is \$75. A supervising MD charges 20% of the IHCP's visit charge. MDs earn \$105 per hour, including benefits.
Data:	N/A
Calculations:	1.52 $_{IHCPs\ per\ MD}$ x 8 $_{IHCP\ visits\ per\ day}$ x 246 $_{days\ per\ year}$ x \$75 $_{IHCP\ charge}$ x 20% $_{administrative\ fee}$ = \$44,870 in supervision and administrative fees accrued to MDs per year \$105 $_{MD\ earnings}$ x 8 $_{hours\ per\ day}$ x (246 $_{workdays}$ – 30 $_{personal\ days}$) = \$181,440 per year in MD self-generated earnings \$44,870 $_{earnings\ from\ IHCP\ administrative\ fees}$ / \$181,440 $_{year\ in\ MD\ self\text{-}generated\ earnings}$ = 24.7% of supervising MD income from administrative fees associated with IHCPs.

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	(575,000 active MDs x $44,870 earnings from IHCP administrative fees) x 1/3 IHCP-supervising MDs = $8,600,160,000 per year in MD earnings from IHCP administrative fees
Conclusion:	This model suggests supervising MDs may gain 24.7% of their incomes and $8.6 billion across the nation from administrative fees associated with care delivered by IHCPs. Prior to the development of ABC codes, an MD trade association was the primary coding authority for health interventions, whether MD or IHCP. Many of the codes for IHCPs developed by this coding authority were not sufficiently granular to support direct billing by IHCPs. IHCPs could bill directly if they had access to ABC codes.

Additional Benefits Will Be Generated From Increased Market Participant Interaction

The benefits of increased interaction among market participants as a result of ABC code set implementation parallel those that would accrue from deployment of consumer-centric and interoperable NHII.

Data on the care reflected by ABC codes will be available to health policymakers. More than 3 million IHCPs and more than 1.6 billion outpatient patient encounters will become visible to health policymakers. Gaps in the HIPAA codes, as well as in the NHII, will no longer compromise critical societal endpoints including individual and public health, business and industry efficiencies, and socioeconomic development.

Alternative Link has previously provided evidence that the adoption of ABC codes could result in

1. greater administrative, financial and clinical efficiencies in the healthcare system;
2. a slowdown in the medical price index (MPI);
3. health policy decision-making improvements based on complete, accurate and precise data;
4. reduced public health risks (e.g., from bio-terrorism and viral epidemics) that could have been overlooked using public health surveillance systems without ABC codes;
5. reduced individual health risks (such as medical errors and adverse reactions);
6. reduced disparities in care medically underserved populations (e.g., impoverished, rural, ethnic and minority populations) and an improved ability to counter preventable conditions such as obesity, cardiovascular disease and diabetes, especially in Native American, Hispanic and African American populations;
7. an increased ability to compare the economic and health outcomes of different approaches to care and different caregivers to identify the best practices;
8. stabilization of health insurance premiums for U.S. employers and associated economic growth;
9. less budgetary pressure on, and fewer benefit cutbacks in, Federal, state and military health plans;
10. elimination of restraint of trade and inequitable exposure to fraud and abuse charges for IHCPs (disproportionately affecting protected populations, such as racial and ethnic minorities and females, among the allied and public health, nursing, CAM and integrative health professions);

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11. a shift toward prevention of illness and a greater orientation toward wellness;
12. achievement of Congressional intent under HIPAA;
13. a better foundation of standards for a consumer-centric and interoperable NHII; and
14. the saving of more than 1,000 American lives every 20 days (just from avoidance of preventable hospitalizations and hospital-based errors and infections).

ABC Codes Lead to Medical Cost-savings

Medical cost-savings models and evaluations are beyond the scope of this cost-benefit report, since they involve the application of ABC codes in areas other than HIPAA transactions. Nonetheless, the Company views them as highly relevant to CMS interests, since the Medicare program, and health plans that follow that program's lead, could achieve significant cost-savings through controlled coverage and reimbursement of IHC in areas of care that are responsive to these approaches to care.

Table 63. An ACA-funded study found that Medicare patients who utilized chiropractic services utilized $3,677 less per year in healthcare.

A study of Medicare's Standard Analytical Files for 1999,[213] titled "Utilization, Costs, and Effects of Chiropractic Care on Medicare Program Costs," compares the global, per capita Medicare expenditures of chiropractic patients to those of non-chiropractic patients receiving care in the federal Medicare program. Average Medicare payments were $4,426 for beneficiaries who received chiropractic care and $8,103 for those that did not. Those who received chiropractic care averaged fewer Medicare claims and lower average Medicare payments per claim per capita than those who did not.

To develop medical cost-savings models, demonstration sites used literature and topic reviews, systematic reviews and meta analyses, as applicable, to identify the high cost diagnoses most responsive to IHC.

For selected diagnoses, the demonstration sites then quantified the annual cost of care using conventional, complementary and alternative practitioners.

Finally, demonstration sites identified specific areas for displacement and/or improvement of conventional medical approaches to care using IHC (e.g., focusing on medical cost-savings achievable through modified approaches to care).

Table 64. Low back pain is the most expensive source of workers' compensation costs and, for individuals 30-50 year of age, the most expensive healthcare problem in North America.

The annual cost of low back pain (including productivity losses) has been estimated at more than $60 billion. Early research suggested low back pain related disability was growing 14 times faster than the population and was the leading cause of disability and morbidity in middle-aged persons, the most expensive source of workers' compensation costs, and, in the 30-50 age group, the single most expensive healthcare problem in North America.[214]

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One site, MediMerge Health, submitted the following comments and data under 45 CFR 162.940.

Table 65. MediMerge used ABC codes to help a Fortune 200 company improve the quality of care delivered to employees, stabilize premiums and give employees access to cost-effective IHCPs.

"ABC codes reflect allied and public health, nursing, CAM, and integrative healthcare interventions with greater precision than that provided by HCPCS codes. For example, MediMerge used ABC codes in development of its 'Back Pain Disorders Trigger Guideline' to define optimal sequencing and timing of interventions by integrative CAM practitioners, nurses and physicians to improve the health of plan members, maximize the quality of care for the targeted condition(s) and reduce the cost to health plan sponsors. The…proprietary table (see Exhibit U) illustrates the importance of precise coding to this effort. For example, in the area of massage, bodywork and somatic education, ABC codes offered substantially greater precision in describing optimal care within our intervention process than did CPT codes. MediMerge estimates this Guideline for Pain would save the Medicare, Medicaid, DOD, VA and OPM programs 8% in medical costs in year 1, with cost-savings of 15% in year two and 23% in year three."

As Exhibit U illustrates, the medical cost-savings were largely driven by the ability to completely, accurately and precisely guide care using a combination of ABC, CPT and HCPCS II terminology and codes.

MediMerge used actual claims data to substantiate cost-savings with a Fortune 200 client, in deploying similar guidelines for the diagnoses on the second page of Exhibit U. Noteworthy medical cost-savings were documented for each diagnosis. [215]

This demonstration site illustrated the ability of ABC codes to improve clinical pathways and reduce the total cost of care.

A second demonstration site, Bridges in Medicine[216] compiled data on the frequency of diagnoses for which seniors in a Medicare Advantage plan sought IHC.[217] The frequency distribution is illustrated in Exhibit V.

Table 66. A Medicare Advantage PPO is using ABC codes in conjunction with HCPCS codes to compare the economic and health outcomes of conventional, complementary and alternative approaches to care, delivered by MDs and IHCPs.

Bridges in Medicine is using ABC codes and practitioner identifiers to compare economic and health outcomes of conventional, complementary and alternative approaches to care. The PPO is also comparing cost and clinical outcomes of MDs and IHCPs.

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The site also reported on the frequency with which specific categories of IHC interventions were provided to patients in support of specific diagnoses. The hierarchic structure of the code set made this easier, since queries could be run on the first three characters of the ABC code field to group related interventions, such as acupuncture. The fourth page of Exhibit C illustrates the diagnoses for which acupuncture treatments (as a category) were used. The granularity of the ABC code set made possible derivative pie charts based on individual ABC codes.[218]

Bridges in Medicine is in the process of compiling medical cost-savings data based on a comparison of conventional and integrative diagnostic and treatment pathways.[219] The organization has already made public the qualitative outcomes of using ABC codes: [220]

Table 67. Bridges in Medicine documented improvements in the financing, administration and delivery of care as a result of ABC code set deployment. Benefits accrued to patients, MDs, IHCPs and a Medicare Advantage program.

In relation to ***clinical delivery***, use of ABC codes improved patient-practitioner, practitioner-practitioner and practitioner-payor relationships; improved understanding of optimal treatment pathways (e.g., equally or more effective, less invasive interventions with lower costs); and improved outcomes, especially for chronic conditions (e.g., fewer side effects). In relation to ***administration***, ABC codes supported more constructive inter- and intra-organizational interactions and optimal allocation of organizational resources. In relation to ***financing issues***, ABC codes helped improve contracts and revenues; improve operating efficiencies and improve the bottom line. ABC codes helped provide ***patients*** with knowledge and ability to adopt a proactive approach to their total well being. The codes help the patients' caregiver deliver healthcare education for more informed decision making; take a patient-centric approach and use a professional healthcare team; promote open communication between patient and practitioners in a highly supportive environment; assure active participation by the patient in his/her own healthcare; and commit to long-term healthcare through a focus on restoring and maintaining good health, wellness education, and follow-up visits. ABC codes gave ***practitioners*** a mechanism for integrating a care plan, so they could improve patient records; identify outcomes of care and develop best practice pathways; prove legality, necessity and cost-effectiveness; use payors' language and show what's in it for them; reduce contracting, credentialing, coverage, claims management and reimbursement concerns; and focus on the patient. ABC codes helped the ***health plan*** improve benefit plan design and streamline contracting; optimize utilization and care practices; cost-effectively adjudicate IHC claims; conduct outcomes research; characterize IHC models, previously not clearly delineated; collect hard data on care-effective and cost-efficient models useful in managing resource intensive conditions; and support risk management and other actuarial needs.

The use of IHC in this setting resulted in measurable improvements in financial performance, especially in relation to patients with chronic conditions.

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Table 68. A health system gained $107,975 in future value (FV) by treating a single sinusitis patient with IHC instead of conventional healthcare.

Case Study

A patient had been treated nineteen times in six years using conventional therapies and was on prescription medication. The patient visited Bridges in Medicine and was diagnosed with sinusitis. "This pattern was expected to continue for the rest of the patient's lifetime, as the conventional treatment would not completely cure the patient's condition."[221]

At Bridges in Medicine, the patient's IHC treatments included eight acupuncture, six chiropractic, four healing touch, three nutrition and one allergy specialist visit over the course of three months. The patient recovered and maintained a significantly improved quality of life. The total cost was $1,772.

Conventional treatment had cost $2,364 over six years, or $394 per year. Integrative care cost $1,772. The patient's lifetime treatment (over 50 years) would have cost $22,064. Considering the time value of money (at 7% APR), the future value (FV) of the cost of ongoing conventional treatment at the end of patient's life would have been $160,172, while the FV of the integrative treatment at the end of the same period of time would have been $52,197.

The health system gained $107,975 in FV and experienced greater patient and employer loyalty as the patient's improved quality of life resulted in greater work productivity.

Beyond the demonstration sites, recognition of the medical cost-savings potential of IHC is growing.

The International Foundation of Employee Benefit Plans (IFEBP) reports that alternative medical treatments are gaining popularity as a covered benefit in employer-sponsored health plans.

Table 69. Some CAM interventions are almost "mainstream."

About 47% of employees with health benefits had acupuncture coverage in 2004, up from 33% in 2002.[222]

Chiropractic coverage increased from 79% to 87% of workers with health benefits, according to a 3,000-employer survey released in September 2004 by the Kaiser Family Foundation and Health Research and Educational Trust.

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Many IHC interventions are gaining acceptance.

Table 70. Health plan coverage and reimbursement of CAM is growing, even for unconventional interventions such as homeopathy.

Mercer Human Resource Consulting reported in 2003 that, in their largest medical plans, 13% of large employers surveyed covered massage therapy, 7% covered homeopathy and 7% covered biofeedback.

Cost containment is a major factor in increased coverage of IHC as healthcare costs continue to rise 7% to 15% per year.[223] To counteract this, employers are requiring employees to pay more out-of-pocket expenses for healthcare coverage and are offering consumer-driven health plans (CDHPs) that make employees more accountable for healthcare spending. CDHPs give employees greater first dollar access to IHC.

Table 71. Employers are recognizing that cost-effective care delivered by IHCPs can stabilize premiums, support employee recruitment and retention, and improve labor productivity.

Waste Management Inc., a Houston-based waste-collection and disposal company that employs nearly 52,000 people, removed a cap that had been placed on its chiropractic coverage. The coverage decision was made to remedy excessive treatment costs and productivity losses associated with musculoskeletal problems, according to David Kasper, the company's benefits director.[224]

Mutual of Omaha reported saving about $6.50 for every dollar it spent covering alternative treatments.[225]

Landmark Healthcare, a CAM network, commissioned a study of HMOs and alternative care in which 114 senior executives of HMOs were contacted. This survey revealed that half of the HMO executives believed coverage of CAM would result in neutral or reduced costs.[226]

Table 72. Workers' compensation programs have documented the cost-benefits of CAM for back problems.

Utah's Workers' Compensation Board reported a $775.30 cost per case for back-related injuries treated by chiropractor versus $1,665.43 per case under conventional treatment. Average compensation was $68.38 for chiropractors and $668.39 for MDs.[227] [228]

Other surveys (one of PCPs in a 45-clinic network and one of patients of licensed naturopathic physicians) also documented that health industry stakeholders believe CAM can reduce costs.

In the first survey, sponsored by Medalia Healthcare, 30% of responding physicians said appropriate use of CAM could provide more cost-effective care, and 69% said appropriate use of CAM could lead to savings under capitated contracts.

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Table 73. The cost of chiropractic and acupuncture visits is sufficiently well documented to support cost-effectiveness analyses.

James Dillard, a medical director of Oxford Health Plans Inc. and medical director at Columbia University's Rosenthal Center for Complementary and Alternative Medicine, reports that a chiropractic or acupuncture visit typically costs about $60 to $80.[229]

In many cases, IHCPs are less costly than their conventional MD counterparts both on a per visit basis and a total cost of treatment basis.

Table 74. IHC can be used in conjunction with, or as a replacement for, conventional MD care.

A review of 395,641 insurance claims for chiropractic and medical care patients revealed that patients who received chiropractic care, either solely or in conjunction with medical care, experienced significantly lower healthcare costs.

Over a two year period, the value of insurance claims for those who received chiropractic either alone or in conjunction with medical care was $1,000. Insurance claims were 30% higher ($1,138) for those who elected medical care only.

The cost difference was attributed to lower inpatient and outpatient costs.

The researcher concluded "chiropractic treatment substitutes for other forms of outpatient care."[230]

No longer viewed strictly as an adjunct to conventional care by Western practitioners, CAM is beginning to be viewed as the treatment of choice for certain diagnoses.

Table 75. CAM services and supplies can reduce reliance on drugs and other conventional medical treatments.

In a survey sponsored by Integration Strategies for Natural Healthcare, 48% of responding patients said they believed CAM treatments had lowered their use of prescription drugs.

68% said that, after seeing a naturopath, they successfully cared for conditions at home for which they would have seen a doctor in the past.[231]

Although the healthcare industry has few systematic analyses comparing the costs and outcomes of conventional versus integrative therapies for the same diagnoses (primarily because of the lack of an accepted code set to facilitate those comparisons), evidence suggests that, for some disorders, CAM therapies can lead to outcomes as good as or better than those from allopathic treatments.

Table 76. CAM can be more clinically effective that conventional drugs.

Duke University Medical Center reported in September 2004 that acupuncture was more effective than *ondansetron* (Zofran®) for reducing nausea and vomiting after major breast surgery.

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For example, chiropractic treatment was found to be significantly more cost-effective than allopathic care in a study of 8,018 episodes of care where chiropractic was compared to conventional treatments for low back pain. The average total payment for first episodes was $1,020 for medically managed episodes and $518 for chiropractic managed episodes. For outpatient treatment, the average was $598 and $447 respectively. In cases with multiple episodes, the average total payment for the first and second episodes were $1,272 and $1,505 for medically managed episodes versus $635 and $658 for chiropractic managed episodes. [232]

In addition to these findings, earlier studies have documented that chiropractic patients tend to be sicker and may have a history of pain not resolved by medical doctors.[233]

In another example, a four-year study of chiropractic utilization in managed health plans suggested possible CAM cost-savings. Study findings suggest chiropractic care in a managed care setting is more cost-effective than conventional care. [234, 235, 236]

The study included 1.7 million patients in a California managed care plan: 1 million without chiropractic coverage and 700,000 with chiropractic coverage. The study revealed that chiropractic care in patients with neuromusculoskeletal (NMS) conditions was more cost-effective on a number of levels:

1. **Total healthcare costs** - Patients with chiropractic coverage experienced 12 percent lower costs than did patients without chiropractic coverage. Much of this reduction was attributable to favorable patient selection.

2. **Low-back pain treatment episodes** - Patients with chiropractic coverage experienced 28 percent lower costs than did patients without chiropractic coverage.

3. **Fewer inpatient stays** - Patients with chiropractic coverage experienced 9.3 stays per 1,000 patients, versus 15.6 stays per 1,000 patients for those without chiropractic coverage.

4. **Fewer MRIs** - Patients with chiropractic coverage experienced 43.2 magnetic resonance imaging (MRI) procedures per 1,000 patients, versus 68.9 MRIs per 1,000 patients for those without chiropractic coverage.

5. **Fewer low-back surgeries** - Patients with chiropractic coverage experienced 3.3 low-back surgeries per 1,000 patients, versus 4.3 surgeries per 1,000 patients for those without chiropractic coverage.

6. **Fewer radiographs** - Patients with chiropractic coverage experienced 17.5 radiographs per 1,000 patients, versus 22.7 radiographs per 1,000 patients for those without chiropractic coverage.

According to the study's authors, these findings could translate into a $47.5 million savings over four years for the 1.7 million-member managed care plan, if all 1.7 million members were provided with chiropractic coverage.[237]

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Table 77. Expanded chiropractic benefits could save the U.S. healthcare system more than $1.4 billion in medical costs.

Hypothesis:	Expanding benefits in even one area of IHC could generate significant system savings.
Method:	Estimate the benefits associated with expansion of chiropractic coverage across all insurance plans.
Assumptions:	83% of health plans include some form of chiropractic coverage.[238] 75% of these (83%) health plans cap visits and expenditures and therefore only cover 50% of clinically appropriate and evidence-based chiropractic care.
Data:	245 million insured U.S. lives (health plans only) $47.5 million in chiropractic savings (noted above) over 4 years for 1.7 million insured lives
Calculations:	($47.5 million $_{\text{chiropractic-related savings}}$ / 4 $_{\text{years}}$) x ((245 million $_{\text{insured U.S. lives}}$)/ (1.7 million $_{\text{insured lives in chiropractic study}}$)) = $1,717,053,589 in savings for proper use of chiropractic benefits ($1,717,053,589 $_{\text{savings}}$)/ (100% - 83%$_{\text{coverage across plans}}$) = $291.9 million in incremental savings from expanded chiropractic benefits to health plan that have no chiropractic benefits ($1,717,053,589 $_{\text{savings}}$) / (83% $_{\text{plans w/chiropractic benefits}}$ x 75% $_{\text{w/capped chiropractic benefits}}$ x 50%$_{\text{chiro coverage improvements}}$) = $775.7 million in incremental savings from improving chiropractic benefits in the health plans that currently cap these benefits $291.9 million new coverage + = $775.7 million in improved coverage = $1.07 billion in savings from optimal chiropractic coverage across all health plans
Conclusion:	Nationalized, this suggests an incremental cost-savings of $1.1 billion from the appropriate expansion of chiropractic benefits across all health plans. (These cost-savings were not noted in the clinical displacement figures noted earlier, since the savings here may be attributable to more than just savings generated by displacement of conventional medical care.)

The medical cost-savings associated with IHC can only be realized through full deployment of ABC codes. The HCPCS code sets do not provide complete, accurate and precise metrics for these approaches to care. Without metrics, the industry has been unable to identify the most cost-effective practices across conventional, complementary and alternative care—or among MDs and IHCPs. Identification of best practices is essential to evidence-based healthcare—and may be the only way to concurrently improve healthcare accessibility and quality while reducing costs.

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Quantitative Data From Demonstration Sites Supports the Cost-Benefit of ABC Codes in HIPAA Transactions

Alternative Link Secured Cost-Benefit Data from ABC Code Set Registrants and Trading Partners

In October 2003, Alternative Link issued written guidance via email to ABC code set registrants, petitioners and self-identified trading partners to request that they reflect on the ten guiding principles for HIPAA standards and make note of the degree to which they believe the ABC codes meet these objectives.[239]

The Company also advised them to keep written notes on the costs and benefits they anticipated and/or had experienced in implementing ABC codes in their operations—whether in HIPAA transactions or in research, management and manual commerce applications.

Alternative Link committed to these entities to routinely issue updates on the industry's adoption of ABC codes and to provide the latest information on ABC codes at www.AlternativeLink.com.

On the Company web site, Alternative Link routinely provides
1. official updates on the commercial and HIPAA-compliant uses of ABC codes,
2. answers to FAQs, and
3. information about how ABC codes are being rolled out across the industry.

Items 2 and 3 are included in Exhibits M and P, respectively.

Alternative Link has also provided registrants, petitioners and self-identified trading partners with lists of resources available to help them implement and evaluate ABC codes. (These resources were mentioned above and are listed near the end of Exhibit M.)

Alternative Link Surveyed More Than 10,000 Participants in U.S. Healthcare on the Costs and Benefits of ABC Codes

About 10,000 unique entities were identified from approximately 13,000 registration records gathered through Alternative Link's web site from organizations and individuals committed to securing their rights to use ABC codes in HIPAA transactions.[240]

To gain a baseline understanding of the perceived cost-benefit about ABC codes among those who expressed interest in the codes, Alternative Link implemented a registrant perception survey during the first 60-day registration period. The survey was included in the registration form. Registrants were informed that filling out the survey would complete their obligations under the cost-benefit evaluation unless they desired a greater level of involvement in subsequent cost-benefit evaluations.[241]

9,661 organizations and individuals responded to the survey.

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Of this population,
- 65.4% anticipated benefits to public health,
- 67.5% anticipated benefits to the U.S. healthcare industry,
- 44.3% anticipated benefits to their organizations,
- 67.9% anticipated benefits to their professions,
- 60.8% anticipated benefits to their own jobs and/or careers, and
- 59.7% anticipated benefits to themselves as consumers.

In contrast, among this population,
- 10.0% anticipated challenges or increased costs to public health,
- 10.3% anticipated challenges or increased costs to the U.S. healthcare industry,
- 7.6% anticipated challenges or increased costs to their organizations,
- 9.4% anticipated challenges or increased costs to their professions,
- 9.6% anticipated challenges or increased costs to their own jobs and/or careers, and
- 6.2% anticipated challenges or increased costs to themselves as consumers.

67% invited direct communication from Alternative Link to learn more about the respondents' perspectives on these cost-benefit issues.

Survey results are included as Exhibit O.

In 2003, CMS secured from Alternative Link the registrant database, with names and tax identification numbers of registrants.[242]

Registered health plans included some of the nation's top Medicaid and commercial health plans.

Among the health plan registrants were
- Aetna
- Alaska Medicaid (Alaska Division of Medical Assistance)
- American Healthcare Alliance
- American WholeHealth Networks
- BCBS of Northeastern New York
- BCBS Western New York
- California Medicaid (California Department of Health Services)
- Department of Veterans Affairs
- District of Columbia
- Harvard Pilgrim Health Care
- Humana
- Illinois Medicaid (Illinois Department of Public Health)
- Indiana Medicaid (Family and Social Services Administration of Indiana)
- Kaiser Permanente Insurance
- Kentucky Medicaid (Commonwealth of Kentucky)
- Maine Medicaid (State of Maine Bureau of Medical Services)
- Minnesota Medicaid (State of Minnesota Department of Human Services)
- Montana Medicaid (Montana Department of Public Health and Human Services)

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- New Mexico Medicaid (New Mexico Human Services Department)
- New York Medicaid (New York State Department of Public Health)
- Oxford/UnitedHealth Group[1] [2]
- Pennsylvania Medicaid (Pennsylvania Department of Public Welfare)
- South Carolina Medicaid (South Carolina Department of Health and Human Services)
- Tennessee (Bureau of TennCare)
- Department of Veterans Affairs

Registered healthcare information technology (HCIT) companies included brand name players so large that, in combination, they serve the IT needs of the vast majority of the nation's health industry organizations and practitioners.

Among these were

- 3M Worldwide
- Aviacode
- EDS (Electronic Data Systems)
- Epic Systems Corporation
- Fox Systems, Inc.
- HSS
- IDX
- McKesson/HBOC Corporation
- MedPoint Management
- NaviMedix
- OAO HealthCare Solutions, Inc.
- Parexel
- Plexis Healthcare Systems, Inc.
- QuadraMed Corporation
- Siemens Medical Solutions Health Services
- TriZetto
- WebMD Envoy/ViPS
- Zebec Data Systems, Inc.

Since CMS subsequently confirmed that trading partners could use ABC codes in electronic commerce with the registrants,[243] ABC codes have the potential to be evaluated and adopted up and down the healthcare vertical and across the continuum of care, among millions of trading partners.[244]

§ 162.940(a)(1) Comparison to a Current Standard

ABC codes compare favorably to the HIPAA code sets. The ABC code set is about half the size of the HCPCS CPT codes owned by the AMA and almost twice the size of HCPCS II.

Table 78. In terms of number of codes issued, ABC codes fall between CPT codes and HCPCS II codes.

The ABC code set includes 4,183 codes (2004), including 1,972 IHC services and 2,211 supply items, nutraceuticals and homeopathic preparations.
The CPT code set includes 8,262 codes (2004).
The HCPCS II code set includes an estimated 2,400 codes (2004).

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The 500-page 2004 version of the ***ABC Coding Manual for Integrative Healthcare*** includes all current ABC codes in 5-character format, corresponding hierarchic intervention descriptions, and expanded definitions (straightforward professional terminology associated with the intervention, that limit the need for claims attachments).

The ***ABC Coding Manual for Integrative Healthcare*** includes

- procedure and supply item/product index for quick code reference,
- tables that map professional certifications and specialties to 2-character "practitioner identifiers" that can be used as code modifiers,
- crosswalks to the NIC, Omaha and HHCC nursing terminologies and code sets,
- code use instructions by code section and practitioner type,
- samples of completed CMS-1500 and UB-92 claim forms,
- examples of code use for a broad range of practitioner types,
- a sample Superbill (patient encounter form), and
- instructions and a form for requesting additions or changes to the code set and/or associated terminology.

With a hierarchic structure[245] and a greater number of potential code combinations than the purely numeric or mixed alphanumeric HCPCS CPT and II codes, ABC codes can be used to describe over 11 million health interventions.

Table 79. The design of ABC codes offers more than 11 million unique coding possibilities. HCPCS II offers 260,000. CPT offers 100,000.

The total number of integrative health interventions that can be represented by ABC codes (given the 5-character alphabetic format of the ABC code set) is 26^5 or 11,881,376.

The total number of interventions that can be represented by CPT codes (given the 5-character numeric format of the CPT code set) is 10^5 or 100,000.

The total number of interventions that can be represented by HCPCS II codes (given the 5-character format with an alphabetic first position followed by numeric characters in the remaining four positions) is 26×10^4 or 260,000.

Thus, ABC codes offer millions more unique coding possibilities than HCPCS.

Because of the expandability inherent in the design of the ABC code set, ABC codes are less likely to face challenges of expandability and granularity than the CPT and HCPCS II code sets. Yet, as noted above, ABC codes fit into the same insurance forms, data fields, software applications, information systems and business processes as the HIPAA code sets. ABC codes were designed from the ground up, specifically for HIPAA compliance and expandability.[246] They also offer functionality beyond HIPAA requirements.

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The HHS website (http://www.cms.hhs.gov/medicare/hcpcs/codpayproc.asp) makes clear the need for a complete set of standardized codes to support health insurance programs in processing claims for payment:

> Each year in the United States, health care insurers process over 5 billion claims for payment. For Medicare and other health insurance programs to ensure that these claims are processed in an orderly and consistent manner, ***standardized coding systems are essential***. The HCPCS was developed for this purpose. The HCPCS is divided into two principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of CPT-4, a numeric coding system maintained by the AMA. The ***CPT-4 is*** a uniform coding system consisting of descriptive terms and identifying codes that are ***used primarily to identify medical services and procedures*** furnished by physicians and other health care professionals. These health care professionals use the CPT-4 to identify services and procedures for which they bill public or private health insurance programs. Decisions regarding the addition, deletion, or modification of CPT-4 codes are made by the AMA. The CPT-4 codes are republished and updated annually by the AMA. ***Level I of the HCPCS, the CPT-4 codes, does not include codes needed to report medical items or services that are regularly billed by suppliers other than physicians***.
>
> ***Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT-4 codes***, for example, ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when ***used outside a physician's office.*** Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT-4 codes, the level II HCPCS codes were established for submitting claims for these items. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by 4 numeric digits, while CPT-4 codes are identified using 5 numeric digits.
>
> HCPCS level II permanent codes are maintained jointly by…(AHIP, BCBSA and CMS).
>
> Prior to December 31, 2003, ***Level III HCPCS were developed and used by Medicaid State agencies, Medicare contractors, and private insurers in their specific programs or local areas of jurisdiction.*** For purposes of Medicare, level III codes were also referred to as local codes. Local codes were established ***when an insurer preferred that suppliers use a local code to identify a service, for which there is no level I or level II code, rather than use a "miscellaneous or not otherwise classified code."*** The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required us to adopt standards for coding systems that are used for reporting health care transactions. We published, in the Federal Register on August 17, 2000 (65 FR 50312), regulations to implement this part of the HIPAA legislation. These regulations provided for the elimination of level III local codes by October 2002, at which time, the regulations provided, only the level I and level II code sets could be used. We decided to eliminate local codes because ***local codes do not support the objectives of the HIPAA legislation, which calls for an efficient coding system that meets uniform standards and requirements. The elimination of local codes was postponed***, as a result of section 532(a) of BIPA, which directed us to maintain and continue the use of local codes ***through December 31, 2003***.

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Like CPT and HCPCS II codes, ABC codes are "a comprehensive and standardized coding system that describes" health interventions and the ABC code set is a "system for identifying items…not a methodology or system for making coverage or payment determinations, and the existence of a code does not, of itself, determine coverage or non-coverage for an item or service. While these codes are used for billing purposes, decisions regarding the addition, deletion, or modification of…codes are made independent of the process for making determinations regarding coverage and payment."[247]

Unlike CPT and HCPCS II codes, ABC codes were developed for ***both*** HIPAA compliance and a consumer-centric and interoperable National Health Information Infrastructure (NHII). The codes are designed with sufficient precision to support use in healthcare research, management and commerce to generate improvements in the financing, administration and delivery of care. In contrast, CPT and HCPCS II were developed "for the purpose of efficient claims processing…primarily for billing purposes." [248]

ABC codes offer the benefit not only of filling gaps in the CPT and HCPCS II codes, but also of representing many retiring HCPCS III and other local codes.

The majority of HCPCS III and local codes were developed as temporary ways to address gaps in national code sets, e.g., to represent areas of care relevant to regional population health management or to the design of specific health insurance benefit plans.

In addressing the practices of IHCPs, ABC codes provide a lasting solution to the challenge of coding interventions that may not yet have national prevalence or widespread acceptance among the conventional medical community.

To allow for impartial assessments of the economic and health outcomes of different health interventions, consistent with stated NHII endpoints and public health surveillance—brand name or otherwise—ABC codes include scientific descriptions of services and products, as well as brand and trade names (the latter upon formal request).

The inclusion of both scientific descriptions and brand name descriptions of health interventions generates a noteworthy cost-benefit in relation to HIPAA and the NHII. It improves public health surveillance by supporting early identification of both *best practices* and interventions that may represent a public health risk.

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Table 80. Complete, accurate and precise coding for FDA-approved interventions is essential to post-market surveillance—*especially* in the months immediately following FDA approval.

Two competing devices for laser therapy may offer the different treatment costs and different levels of clinical effectiveness.

If Device A offers a treatment cost of $100 and complete healing within 24 hours, while Device B offers a treatment cost of $200 for each of two visits a 50% chance of complete healing within 48 hours and a 50% chance of life threatening complications, both third party payors and the Food and Drug Administration (FDA) would benefit from the "early warning" that could be generated by use of brand-specific coding.

With such early warning, a health plan could deny coverage and reimbursement for Device B. In doing so, the health plan would

1. save no less than $200 per diagnosed patient preauthorized for treatment, and
2. save no less than $100 for each avoided emergency room visit.

With such early warning, the FDA could determine whether a product recall was warranted and could thereby

1. prevent suboptimal use of practitioner time (through elimination of a second visit),
2. prevent unnecessary medical costs (through avoided emergency room visits),
3. improve economic productivity (e.g., by keeping employees constructively at work) and
4. reduce human suffering and loss of lives (e.g., by preventing life threatening complications).

Quantification of these areas of savings is beyond the scope of this report.

ABC codes describe health interventions that any practitioner association or SIG would be challenged to address impartially because of

1) their need to represent the political and financial interests of their members,[249] and
2) their tendency to include subjective "technology assessment" steps in reviewing the care delivered by other practitioner types.[250]

As noted above, according to the HHS website, "Level I of the HCPCS, the CPT-4 codes, does not include codes needed to report medical items or services that are regularly billed by suppliers other than physicians."[251]

Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT-4 codes, for example, ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office."[252]

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These codes are developed and maintained by the HCPCS National Panel, the CMS HCPCS Workgroup and the Alpha-Numeric Editorial Panel, the last of these comprised of representatives of the Blue Cross/Blue Shield Association (BCBSA), America's Health Insurance Plans (AHIP) and CMS.

ABC codes describe health interventions and reflect appropriate consideration of and a focus beyond

1. interventions for which coverage and reimbursement determinations are imminent (e.g., as opposed to those most relevant to public health surveillance or correcting health disparities);
2. FDA approved products that have been on the market for 6 months or longer;[253]
3. intervention pricing, volume and other payors-relevant factors;[254] and
4. subjective "technology assessments."[255]

Practitioner identifiers used with ABC codes as code modifiers provide unique functionality that

1. generates a noteworthy cost-benefit and
2. is essential to the management of care, claims and outcomes associated with allied and public health, nursing and CAM practices.

State laws for these practices vary significantly, unlike state laws for conventional physician practices. IHCP care that is legal in one state may be illegal in another. Thus, for IHCP interventions, the modifiers are essential in establishing legal scope of practice in support of

- benefit plan design,
- managed care and provider contracting,
- utilization and clinical practice management,
- claims processing,
- outcomes research and
- actuarial analyses.

In contrast, the HCPCS codes use 5-character numeric (Level I/CPT) or alphanumeric (Level II) code strings that may or may not be followed by 2-character modifiers. When modifiers are used, they do not consistently identify a practitioner type and may instead provide more information about the patient encounter, e.g., its complexity or resource demands. HCPCS codes focus on conventional medical practices, where identification of practitioner type is less essential to ensuring compliance with laws, regulations and legal precedents.

In particular, the practitioner identifiers and code modifiers used with ABC codes offer payors the benefit of supporting automated determinations of the compliance of caregivers with scopes of practice established by statutes, administrative regulations and case law.

HCPCS codes are less precise or "granular" in describing IHC. HCPCS coding authorities are less familiar with the nuances of IHC and more focused on the needs of conventional caregivers.

ABC codes serve as impartial metrics by precisely describing IHC interventions—whether use of the IHC intervention is growing, prevalent or declining.

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ABC codes are issued on the basis of official terminology in the various fields of IHC. Unlike the HCPCS sets, their development is not influenced by allopathic "technology assessment" filters that may limit the healthcare industry's ability to objectively measure the financing, management and delivery of care.

By ensuring all areas of care are represented more completely, accurately and precisely, ABC codes make possible head-to-head comparisons of the economic and health outcomes of conventional, complementary and alternative interventions, delivered by MDs or IHCPs

Like HCPCS code sets, ABC codes support the development of appropriate "relative values" for the interventions they describe. These relative value determinations support contracting, pricing of services and third party payment. Without intervention-specific relative value determinations, these practices are essentially locked out of the "consideration set" of insurers, self-insured employers and health plans interested in offering IHC to covered beneficiaries. Further, codes that are too imprecise to support assignment of relative values may be require attachments to substantiate pricing and may be subjected to manual rather than automated review when included in insurance claim forms.

In summary, ABC codes compare favorably to current standards.

ABC codes provide functionality and benefits that are essential to the delivery of health promoting, medically necessary, cost-effective, evidence-based and legal care. Without the proper coding supported by the ABC code set, the nation's best IHC practices may remain outside mainstream healthcare—even if they are instrumental to individual and public health, business and industry efficiencies, and the ability of U.S. employers to meet their bottom line earnings projections and support socioeconomic development.[256]

§ 162.940(a)(1)(i) Improve the efficiency and effectiveness of the healthcare system by leading to cost reductions for, or improvements in benefits from, electronic healthcare transactions.

ABC codes improve the efficiency and effectiveness of the healthcare system by leading to cost reductions for, and improvements in benefits from, electronic healthcare transactions.[257]

ABC codes improve efficiencies and effectiveness both under and beyond HIPAA. The codes may be used by anyone in research, management and manual commerce applications, since these uses are unregulated and beyond the scope of HIPAA.[258] The codes have been used commercially in these applications since the late 1990s.

Alternative Link has documented a growing base of health industry stakeholders who recognize the cost-benefit of ABC codes beyond HIPAA transactions, especially in relation to the four objectives of the NHII:[259]

1. Informing clinical practice
2. Interconnecting clinicians
3. Personalizing care
4. Improving population health

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Table 81. VA, Harvard, McKesson, 3M, Elsevier and other requests help substantiate the benefits of ABC codes up and down the healthcare supply chain and across the continuum of care.

Alternative Link received information and code requests from organizations such as…
1. **Department of Veterans Affairs** personnel, for outcomes research in nursing care;
2. **Harvard**, for design of IHC clinic development guidelines under a grant from the **National Center for Complementary and Alternative Medicine** (NCCAM);
3. **McKesson**, for ABC coding education for the payor users' group;
4. **Elsevier**, for enhancement of concept research capabilities; and
5. **3M**, for expansion of data modules used in a broad range of health industry applications.

Use of ABC codes in electronic data interchange (EDI) is regulated under HIPAA. ABC codes are in early-stage use in electronic commerce, since
1. many health industry stakeholders are still challenged to comply with other areas of HIPAA,
2. HHS mandated that code set use be restricted to registered code set users and their trading partners,[260] and
3. the codes support IHCPs many of whom are relatively inexperienced in EDI and unfamiliar with HIPAA transactions and code sets.

ABC codes extend HIPAA-related efficiencies and effectiveness to IHC practices. The codes support the financing, management and delivery of cost-effective and evidence-based care. They offer functionality and benefits critical to areas of healthcare that are subject to widely varying state laws—functionality that is not offered by prior code sets and that is essential to IHC practices, even when those practices are offered by conventional MDs.[261] These codes are particularly relevant to rural and medically underserved populations and to individuals for whom conventional MD-driven healthcare is not effective[262] or is not an option.[263] [264]

In contrast, the HIPAA code sets focus on the practices of conventional MDs. The resulting gaps in the HCPCS code sets prevent head-to-head comparisons of the economic and health outcomes of conventional, complementary and alternative care, as well as MDs and IHCPs.

They lead health and medical policy-makers to rely on incomplete, inaccurate and imprecise data in formulating solutions to pressing healthcare challenges, e.g., challenges relating to access, quality and cost-management.

They leave health industry stakeholders with inadequate information to design health insurance benefit plans, establish managed care and provider contracts, manage utilization and clinical practices, process claims, conduct outcomes research and perform actuarial analyses.[265]

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Table 82. The gaps in HIPAA code sets can lead health practitioners to use incorrect codes and can create legal risks and financial challenges vis-à-vis fraud and abuse regulations and delayed payments.

Gaps in the HIPAA code sets can lead underrepresented health practitioners to engage in fraudulent billing, as they default to describing delivered care with ill-fitting HCPCS codes. They can also create financial hardships and ethical challenges for these predominantly female and frequently ethnic caregivers. Without ABC codes, IHCPs can bill 1) health plans directly with ill-fitting codes and expect payment delays, denials or discounts, 2) bill health plans through MDs and allow the MDs to add an administrative fee that increases the cost to the healthcare system, with an unknown cost-benefit, and/or 3) bill patients on an out-of-pocket basis and deny care to those who cannot afford it.

The CMS "Impact Analysis" suggests the net benefits of deploying a HIPAA standard increase with the number of users and can be expected to accrue after the third year of implementation.[266] Despite regulatory restrictions on ABC code set deployment and use of the codes in controlled settings with limited numbers of users, Alternative Link has demonstrated a break-even point for ABC codes of as little as 12 months after code set deployment.

As restrictions are lifted, as more entities begin to use the codes synergistically, and as time passes, even more evidence of the code set's cost-benefit will become apparent.

The Company remains involved in code set deployment initiatives with a broad range of health industry stakeholders previously reported to CMS (e.g., ABC code set registrants, trading partners and business associates), as well as other entities, such as SSOs.

Through routine business operations, Alternative Link will continue to gather evidence of the cost-benefit of ABC codes in HIPAA transactions and other applications (e.g., research, management and manual commerce).

The high costs associated with HIPAA transactions for IHC claims result from the inability of most automated claims adjudication (auto-adjudication) systems to automatically disposition these claims.

For health plans, healthcare clearinghouses and providers/practitioners to conduct HIPAA and Office of the Inspector General (OIG) compliant transactions for IHC, they need

1. complete, accurate and precise 5-character codes that fit into existing forms, data fields, software applications, information systems and business processes;
2. electronic versions of the expanded definitions of interventions (to eliminate the need for attachments);
3. intervention and line item specific identifiers (not just electronic claim form specific taxonomy codes) that reveal practitioner type;
4. the ability to determine whether a specified practitioner had appropriate training;
5. a relative value unit for each intervention;

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6. a legality determination for each intervention, based on which practitioner provided the care and the region in which the care was provided;
7. a clinical appropriateness assessment based on each intervention, the diagnosis and the practitioner type; and
8. a cost-effectiveness assessment relative to other care options.

Recognizing these needs, Alternative Link maintains a database of

- terminology that reflects the vocabularies of the IHC professions;
- 5-character alphabetic codes;
- hierarchic descriptions that alphabetically group related interventions;
- expanded definitions that help eliminate certain paper-based claims attachments;
- practitioner identifiers in the form of 2-character code modifiers;
- training standards for each intervention;
- relative values; and
- legality assessments and rationale for each intervention, practitioner type and region.

Alternative Link allies maintain databases of

- clinical appropriateness assessments based on each intervention, the diagnosis and the practitioner type; and
- cost-effectiveness assessments relative to other care options.

Development and use of coding in allied and public health, nursing, CAM and integrative health is necessarily different from development and use of coding in conventional care.

In the decade since NCVHS first pointed out major challenges with CPT and HCPCS II codes, the HIPAA coding authorities have not overcome the challenges of

1. missing, incomplete or rapidly evolving vocabularies that describe professional training and practices;
2. inadequate differentiation of practitioners who may operate within a single profession but may have considerably different levels of training and competence;
3. early-stage relative value assessments in need of refinement;
4. variability in legal scope of practice on a per intervention, per practitioner and per state basis, based on state statutes, administrative regulations and case law;
5. different training standards for different caregivers in different states; or
6. limited data on the safety, efficacy and/or cost-effectiveness of these interventions (exacerbated by a historic lack of coding).

The lack of ABC codes and corresponding data elements could lead health plans to deny coverage and reimbursement for otherwise cost-effective care merely because of the expenses associated with managing claims—an unfortunate possibility in an increasingly evidence-based and consumer-driven healthcare environment.

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Health industry stakeholders also data on the cost-effectiveness of the IHC intervention and caregiver relative to more conventional approaches to care and conventional caregivers such as conventional physicians or dentists. ABC codes and other coding-related solutions are making possible assessments of clinical appropriateness based on the intervention, diagnosis, and practitioner type.

Thus, ABC codes ***reduce costs*** in relation to HIPAA and other electronic healthcare transactions primarily by supporting

1. the conversion of manual business processes to electronic business processes through digitized representation of IHC practices;
2. a more precise understanding of delivered care and the basis for charges, with cost-savings derived from avoidance of attachments or other incremental communications to clarify the nature and value of the delivered care; and
3. the avoidance of incremental manual steps in claims adjudication that would otherwise persist if HCPCS were used that could not support mapping on a code-specific basis to practitioner type, relative value, legal scope of practice, training requirements, clinical efficacy and cost-effectiveness.

ABC codes are especially useful in that they offer immediate cost-savings through avoidance of 1) multiple claims for multi-disciplinary practitioners and 2) attachments or other incremental communications to clarify the nature and value of the delivered care and the qualifications of the caregiver.

As additional IHC practices are added to the ABC code set, ABC codes will be relevant to additional patient encounters.

Use of ABC codes to describe IHC interventions leads to lower costs than use of CPT and HCPCS II codes for these approaches to care. ABC codes are more precise than the vast majority of CPT and HCPCS II codes currently used to submit insurance claims for IHC. For example, ABC codes offer more than four thousand codes that reflect IHC interventions. CPT codes offer about 8,262 codes for conventional physician services, but fewer than a dozen codes (in total) to describe the practices of relatively mainstream CAM practitioners (e.g., acupuncturists, chiropractors, massage therapists) [267] and fewer than a hundred to describe the nursing professions.[268]

The use of precise codes leads to reduced administrative burdens. It leads to less research about the care that was delivered, fewer verification steps to check on the appropriateness, legality and financial value of that care, and reduced paperwork to support utilization and claims management. Reduced administrative burdens lead, in turn, lead to reduced costs and reduced potential for administrative, financial and clinical errors.

In contrast, the use of imprecise (i.e., “generic” or “bundled”) codes for IHC—such as those in the HCPCS code sets—leads to less efficiency and may not fully support Congressional intent under HIPAA.

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Imprecise codes lead to greater administrative burdens. Health administrators must conduct more costly and complex research to understand the value of delivered care. They must take more verification steps to ensure the care was legal and appropriate for the patient's condition. They must demand and process more paperwork to document the medical, legal and economic appropriateness of each patient encounter. These administrative burdens increase costs and the potential for administrative, financial and clinical errors.

For the limited number of IHC practices it does code, the HCPCS code sets typically address unrelated IHC interventions using a single *not otherwise classified* code. These generic codes do not offer a one-to-one relationship between a code and a corresponding healthcare intervention. For example, CPT offers two codes for acupuncture and oriental medicine and four codes for chiropractic services. (This may compared to offering two codes for all of surgery or four codes for all diagnostic and laboratory tests.)

With so few codes describing so many interventions, the ability to relate a code to a specific healthcare service or supply is lost. Also lost is the ability to draw meaningful conclusions about the appropriateness of the care, e.g., for prior authorizations, claims adjudication and utilization review.

Further, as noted in a prior section, CPT codes lack a critical design and data element that is essential for both regulatory compliance (e.g., avoiding fraud and abuse) and critical health industry business processes.[269] [270] [271] The needed design and data element—the alphanumeric code modifier[272] that identifies practitioner type to reflect state-specific licensing—is included in ABC codes. ABC codes, with the modifier, allow for electronic matching of provider type to the state field on a CMS-1500 or UB-92 claim form or standard HIPAA transaction to ensure the delivered care is within the provider's legal scope of practice. ABC codes offers the added value of supporting outcomes research on a per intervention, per practitioner or per state basis—all without compromising HIPAA privacy mandates. A calculation of the cost-savings associated with these benefits is beyond the scope of this report.

Without this modifier, an IHC insurance claim may require more than four times the resources required to process a conventional physician claim.[273] This creates significant inefficiencies for covered entities, trading partners and business associates that offer IHC benefits. It also creates financial pressures that could motivate these health industry stakeholders to withdraw or deny IHC benefits even if the health outcomes are superior to conventional care.

The burden created by imprecise HCPCS codes that lack provider identifiers is so great that many self-insured employers and full insurers have chosen to cap CAM benefits on the basis of total annual visits or expenditures.[274] In some cases, they have done this without considering whether additional CAM visits or expenditures are cost-effective and evidence-based.

The resulting artificial and irrational limits on care reduce the ability of these covered entities to properly manage access, quality and costs for covered populations.

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In contrast to administrative simplification, extra paperwork may be required to justify treatment plans that clearly are in the best interests of patients. If this overwhelms caregivers and health plans, patients may be denied needed care and may end up in more costly emergency care sites, with more expensive complications. A calculation of the costs associated with the limited functionality of HCPCS code sets in relation to IHC is beyond the scope of this report.

ABC codes eliminate the need to control costs by artificially or irrationally capping total annual visits or expenditures or transferring risk to specialty insurers or PPOs.[275] They allow covered entities, trading partners and business associates to manage IHC, claims and outcomes using the same business processes that they apply to the management of conventional MD services.

Use of ABC codes by primary payors can eliminate the need for "carve outs"[276] and "affinity plans"[277] that currently create administrative burdens and result in "silos" of data that interfere with consolidated warehousing and the ability to conduct scientific analyses of the economic and health outcomes of competing approaches to care across competing categories of caregivers. That is, use of ABC codes helps primary payors better manage care, claims and outcomes. A calculation of the bottom-line implications of reducing the necessity of carve outs and affinity plans in favor of more fully integrative benefits is beyond the scope of this report.

Even within the conventional care arena, ABC codes generate noteworthy benefits. ABC codes support direct billing by qualified practitioners and eliminate markups by MDs that may not reflect ***value-added*** services.

In addition to supporting electronic transactions, ABC codes work with the HCPCS code sets to support other essential business processes associated with the financing, administration and delivery of IHC. For example, ABC codes support ***activity-based costing***, ***enterprise resource planning***, and delivery of ***best practices*** by facilitating improved data collection on business process costs, steps and outcomes associated with a broader range of health interventions. A calculation of the cost-savings associated with these benefits is beyond the scope of this report.

Used in conjunction with the HIPAA code sets, ABC codes are essential to supporting reliable research, management and commerce for health interventions relevant to practices, practitioners and populations outside the mainstream. A calculation of the cost-savings associated with these benefits is beyond the scope of this report.

ABC codes improve the data, information and knowledge that can be developed for, and delivered to, broad range of health industry stakeholders and health policymakers. For example, by characterizing culturally competent practices of nurses and MDs, ABC codes are expected to bring greater clarity to challenge of disparities in ethnic and minority health.[278] A calculation of the cost-savings associated with these benefits is beyond the scope of this report.

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By supporting more complete, accurate and precise data collection, analysis and reporting within the NHII, ABC codes are expected to support better decision-making across the entire continuum of care[279] from minority/ethnic neighborhoods to community health programs to academic research centers; from individual patient encounters to treatment paths to disease and health management programs; from alternative through complementary to conventional interventions; and from emerging to prevalent to obsolescent healthcare products and services. A calculation of the cost-savings associated with these benefits is beyond the scope of this report.

Prior to HIPAA, HCPCS Level III/local codes allowed payors to provide IHC benefits that included conventional, complementary and alternative care from both MDs and IHCPs. With these "home grown" codes, payors could precisely describe CAM and nursing interventions they viewed as helpful to their beneficiaries. With HIPAA eliminating local codes and the data capture, warehousing and analysis that those Level III codes supported, many payors have limited means (other than ABC codes) to manage IHC interventions.

Replacing essential functionality delivered by Level III/local codes prior to HIPAA, ABC codes fit in the same insurance forms, data fields, software applications, information systems and business processes. They support utilization management and insurance claim processing functions that are essential in complying with state scope of practice laws. Their precision and unique modifiers help ensure covered entities, trading partners and business associates comply with HIPAA-related fraud and abuse regulations in relation to IHC. They help streamline electronic data-driven business processes such as health insurance benefit plan design, managed care and provider contracting, utilization and clinical practice management, claims processing, outcomes research and actuarial analyses.

In summary, ABC codes offer greater precision, functionality and benefits than CPT and HCPCS II codes vis-à-vis IHC and also serve functions formerly fulfilled by Level III/local codes. The HIPAA-inspired ABC code set supports improvements in administrative simplification in accordance with congressional intent under HIPAA. The codes simplify and, in some cases, eliminate costly administrative procedures. They reduce the need for lengthy explanations of delivered care, manual determinations of the clinical rationale for that care, and labor intensive assessments of the legality and economic benefit of that care.

ABC codes also generate improvements in healthcare research, management, commerce. In contrast—in relation to IHC—the less granular HCPCS codes may not meet all ten guiding principles of HIPAA. The HCPCS codes are more administratively burdensome since they do not provide the design functionality or mapping capabilities needed to support full automation of claims adjudication in areas other than MD care.

Thus, ABC codes improve the efficiency and effectiveness of the healthcare system by leading to cost reductions for, or improvements in benefits from, electronic healthcare transactions.

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§162.940(a)(1)(ii) Meet the needs of the health data standards user community, particularly healthcare providers, health plans and healthcare clearinghouses.[280]

Alternative Link's ABC codes meet the needs of the health data standards user community, particularly healthcare providers, health plans and healthcare clearinghouses.

ABC codes bring the benefits of HIPAA to nearly two dozen categories of healthcare practitioners and support electronic transactions and administrative simplification for thousands of IHC interventions. ABC codes are urgently needed to help healthcare providers, health plans and healthcare clearinghouses electronically manage HIPAA transactions that relate to these practices.

A partial list of supported practitioner types was provided in Table 8.

ABC codes are a critical and missing element of the HIPAA code sets and the NHII standards and are essential in compiling, processing and communicating data to generate greater business and industry efficiencies among covered entities, trading partners and business associates. The codes also give health policymakers a more complete, accurate and precise understanding of the U.S. healthcare system so they can make better policy decisions.

Table 83. More than 10,000 organizations and individuals secured rights to use and evaluate ABC codes under 45 CFR 162.940.

More than 10,000 practitioners, provider organizations, health plans and healthcare clearinghouses registered to secure rights to ABC codes under HIPAA. The majority of these health industry stakeholders were convinced that ABC codes added more benefits than costs in their own organizations and in the U.S. healthcare system. A breakdown of these entities has been provided to CMS under separate cover.

With ABC codes, healthcare providers, health plans and healthcare clearinghouses can better manage care, claims and outcomes. The codes help healthcare providers and health plans avoid fraud and abuse or malpractice charges that could result from use of or reliance on imprecise HCPCS codes that lack practitioner identifiers and fail to support per intervention, per practitioner and per state assessments of legality.[281]

Table 84. Health lawyers recognize the value of ABC codes in reducing fraud and abuse in the areas of IHC.

The leadership of the U.S. Office of Personnel Management recommended a meeting between the OPM Inspector General and Alternative Link to discuss the advantages of deploying ABC codes to support the Federal Employee Health Benefit.[282]

Used in conjunction with HCPCS, ABC codes help medical and health policymakers concurrently improve healthcare access, quality and cost-containment efforts.

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ABC codes support data collection, warehousing and analyses that help health plans design health benefits that can reduce the total cost of care and improve beneficiary health and productivity.

ABC codes help health plans and others make health policy decisions based on more reliable information about what works and does not work in healthcare.

Table 85. ABC codes support a broad range of business processes, such as actuarial analyses, outcomes research, claims processing, utilization and clinical practice management, managed care and provider contracting and health insurance benefit plan design.

The National Medical Director of a leading health plan is facilitating deployment of ABC codes through a series of corporate initiatives to improve actuarial capabilities and derive better evidence of the cost-effectiveness of competing approaches to care. The expectation is that ABC codes will improve data collection, processing, analysis and reporting within the organization.[283]

With practitioner identifiers and corresponding relative values, ABC codes help healthcare providers and health plans establish and manage contracts that clearly define legal scope of practice and compensation.

They enable providers, health plans and others to better manage utilization and the delivery of care, whether that care involves conventional, complementary or alternative practices, MDs or IHCPs.

Table 86. Health plans and PPOs use ABC codes to establish managed care contracts and support coverage and reimbursement for the kinds of care that attract new beneficiaries.

Ardent Health Services' Lovelace Sandia Health Plan relies on ABC codes and corresponding relative values to establish compensation in its contract with Bridges in Medicine. Bridges in Medicine uses ABC codes to assure IHCPs (such as acupuncturists, chiropractors, massage therapists and nutritionists) deliver care within their legal scopes of practice in the State of New Mexico. The relationship between Bridges in Medicine and the various corporate forms of Ardent Lovelace Sandia has been supported by ABC codes for more than five years and has been so successful that the number of covered lives has increased 4,100% over that timeframe.

ABC codes help healthcare practitioners, provider organizations, health plans, third party administrators, administrative service organizations, claims clearinghouses and medical billing services more easily process insurance claims.

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Table 87: Innovators such as Aviacode believe ABC codes expand current markets and open new markets for existing products and services, such as computer-assisted billing.

Aviacode provides online medical coding services for health practitioners and provider organizations. Aviacode is deploying ABC codes to meet the IHC coding and billing needs of its customer base.[284]

ABC codes help medical and health services researchers track, measure and analyze the economic, clinical, health, quality-of-life and patient satisfaction outcomes of care.

The codes make the benefits of actuarial analyses available to health industry stakeholders in areas of care that were lacking effective metrics or scientific measurement tools.

Table 88. Before ABC codes were available, CAM researchers had difficulty collaborating and comparing findings across research centers. ABC codes create data collection standards that ensure data can be pooled and analyzed across centers to improve the quality of research.

Brian Berman, MD, of the University of Maryland is leading an academic consortium of 22 leading medical schools in deploying ABC codes in grant-funded initiatives and the operation of the universities' IHC clinics to support improvements in data collection, analysis and reporting among the CAM centers at these institutions.

ABC codes help healthcare providers and health plans identify and channel patients to cost-effective and evidence-based health interventions.

Table 89. Half a dozen aerospace companies asked their health plans to develop CAM benefits for unionized employees.

ABC codes helped a health plan respond to union requests for CAM benefits. The health plan used ABC codes, practitioner identifiers and other data to support CAM practitioner credentialing.

The relevance of ABC codes to the health data user community is further evidenced by the publicity the code set has received.

ABC codes have been the topic of several radio talk shows, as well as numerous articles in trade publications. The publications that have covered ABC codes include (but are not limited to) the following:

- Advance Magazine for Health Information Professionals
- American Academy of Professional Coders' Coding Edge
- American Health Information Management Association Journal
- Alternative Therapies in Health & Medicine
- Benefits & Compensation Solutions

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- Business Insurance
- ChiroCode Hot Topics Newsletter
- Chiropractic Economics
- Coding & Billing Expert
- Compensation and Benefits Review
- Consumer-Driven Health
- Consumer-Driven Health Plans
- Employee Benefit News
- Holistic Primary Care
- Integrative Medicine Consult
- Integrative Nursing
- International Journal of Yoga Therapy
- Journal of the National Association of Clinical Nurse Specialists
- Managed Healthcare
- Product Management Today
- Workforce Management

The codes have also been addressed in important national and regional conferences.

In July 2003, the **Ardent Health Services / Lovelace Sandia Health System** IHC plans for seniors, that are supported by ABC codes through channeling of patients to Bridges in Medicine (which uses ABC codes in patient encounter forms [superbills], practice management systems, claims management processes, outcomes research initiatives, etc.), were featured at the **Global Health Research Consumer-Directed Health Conference** in Chicago.

Over the 2003 Labor Day weekend, ABC codes were featured in Lake Las Vegas, Nevada, at the **National Foundation for Women Legislators' Annual Meeting** (www.womenlegislators.org). Shortly thereafter, NFWL passed a resolution supporting the extension of coding into all IHC practices, to support consumer choice, individual and public health, business and industry efficiencies, and socioeconomic development. As noted above, copy of the NFWL "Access to Care" Resolution is included as Exhibit N.

In September 2003, ABC codes were featured at the **McKesson Payor Solutions Conference** in Phoenix, Arizona (www.mckesson.com).[285] **McKesson Information Solutions** offers provider solutions that ensure coding is compliant with CMS and other federal agency guidelines, enable providers to perform comprehensive billing checks before claim submission, help reduce processing time and days in accounts receivable, and reduce claim denials. Its solutions for claims management include EDI to streamline business interactions between providers and payors and prevent delays and miscommunications, an EDI clearinghouse that provides HIPAA-enabled transactions to more than 1,300 payors, code editing solutions that check claims for coding accuracy and help payors provide consistent payment based on sound clinical criteria.

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It also provides a comprehensive tool that automatically recognizes and translates millions of medical terminology variations into accurate codes, and code auditing solutions that protect against common errors of duplicate submissions, unbundled services and mutually exclusive services.

Finally, it provides clinical knowledge bases of coding edits that can be integrated with a payor's existing claims processing systems and an Internet disclosure solution that enables payor customers to display their claims payment edits, rules and source information.

ABC codes have also been featured at the following conferences:

- October 18-23, 2003, American Health Information Management Association Conference in Minneapolis, Minnesota.
- October 30-November 2, 2003, Midwives Alliance of North America Conference in Austin, Texas.
- November 6-8, 2003, Congress of Chiropractic State Associations National Conference in Las Vegas, Nevada.
- November 13-17, 2003, American Association of Oriental Medicine Annual Conference in Orlando, Florida.
- November 15-19, 2003, American Public Health Association Annual Conference in San Francisco, California.
- January 8, 2004, ChiroCode Conference in Phoenix, Arizona.
- January 22-24, 2004, Integrative Medicine for Healthcare Organizations Conference, organized by the American Hospital Association and InnoVision (publishers of Alternative Therapies in Health and Medicine), in San Diego, California.
- March 2-3, 2004, Automotive Injury Claims Management Meeting, organized by Mitchell Medical, in San Diego, California.
- March 10-13, 2004, Renaissance in CNS Practice: Transforming Nursing in the 21st Century" at the Annual Conference of the National Association of Clinical Nurse Specialists in San Antonio, Texas.
- March 25-26, 2004, Consumer-Driven Pharmacy Benefits, sponsored by Global Business Research, in Philadelphia, Pennsylvania.
- April 28-May 1, 2004, The Soul of Medicine, sponsored by the American Holistic Medical Association in cooperation with the Academic Health Center and University of Minnesota, in Albuquerque, New Mexico.
- May 14-15, 2004, sponsored by New Mexico Health Resources, Inc., in Taos, New Mexico.
- May 17-21, 2004, The Electronic Patient Record (TEPR) Conference sponsored by the Medical Records Institute, in Fort Lauderdale, Florida.
- May 21-23, 2004, Physicians of Naturopathic Medicine Convention, sponsored by the New Mexico Physicians **of Naturopathic Medicine**, in Albuquerque, New Mexico.

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The next event scheduled is as follows:

- October 14-17, 2004, **Symposium for Integrative Medicine**, at the Office of Continuing Medical Education Program at the **University of New Mexico, School of Medicine**.

Like most systemic changes, ABC code set adoption appears to be a process, not an event. The nationwide adoption of ABC codes is underway, although still in the early stages. The early adopters are primarily progressive health industry stakeholders that already offer IHC products and services and want to identify and properly manage the nation's most cost-effective approaches to care—whether conventional, complementary or alternative, from MDs or IHCPs.

Alternative Link is working with Medicaid programs, commercial health plans, regional/specialty health plans, HCIT companies, provider organizations, IHCPs and others. Most information about these ABC code set registrants is protected under non-disclosure and other agreements. However, certain organizations have not prohibited release of their names, profiles and activities in relation to ABC codes. These include but are not limited to the following:

- Acupuncture and Oriental Medicine National Coalition (www.aomnc.com)
- Aetna (www.aetna.com)
- Alternative Healthcare Options (www.aho-network.com)
- American Healthcare Alliance (www.ahappo.com and www.aha-ppo.net)
- Ardent Health Services / Lovelace Sandia Health System (www.lovelacesandia.com).
- Aviacode (www.aviacode.com)
- Bridges in Medicine (www.bridgesinmedicine.com)
- Carolinas HealthCare System (www.carolinas.org)
- ClaimEDIx (www.claimedix.com)
- Conemaugh Health System (www.conemaugh.org)
- The Consortium of Academic Health Centers for Integrative Medicine (www.bravewell.org/stratinit/consortium.asp)
- Integrative Healthcare Systems (www.integrativehealthcaresystems.com)
- Integrative Medicine Network (www.integrativemedicinenetworks.com)
- JG Global Technologies (www.jggt.com)
- Lovelace Sandia Health System (www.lovelacesandia.com) a business unit of Ardent Health Services (www.ardent.com)
- Medical Professional Systems (www.medicalprosystems.com), a division of American Marketing
- MediMerge Health (www.medimerge.com)
- Mitchell Medical (www.mitchellmedical.com)
- N-CAM Wellness Benefits Company (www.n-cam.com)
- National Association of Clinical Nurse Specialists (www.nacns.org)
- NaviMedix (www.navimedix.com)
- NDCLytec (www.lytec.com)
- Preferred Health Systems (www.phsystems.com)

Details about the ABC coding initiatives underway with these organizations are provided in Exhibits W, X and Y.

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The above-noted code set benefits, the registrations to secure rights to use ABC codes in HIPAA transactions, deployment initiatives among noteworthy stakeholders and trade publications reinforce the fact that ABC codes meet the needs of the health data standards user community, particularly healthcare providers, health plans and healthcare clearinghouses.

§162.940(a)(1)(iii) Be uniform and consistent with other standards adopted under this part and, as appropriate, with other private and public sector health data standards.[286] [287]

ABC codes are uniform and consistent with other standards adopted under this part and, as appropriate, with other private and public sector health data standards.

Alternative Link has been involved with healthcare standard-setting organizations (SSOs) and healthcare information technology (HCIT) organizations since the Company's inception and continues to maintain these essential relationships.

Representatives of Alternative Link have been active with ANSI ANSI X12, HL7, AHIMA, DISA, CPRI, NLM and others.

Designed specifically for HIPAA compliance, ABC codes support the goals of these organizations.

ABC codes were voted into ANSI ASC X12N version 004022 and are included in the draft implementation guide for ANSI ASC X12N version 004050.

ABC codes are a registered vocabulary of HL7.

ABC codes were favorably reviewed in several articles in AHIMA and DISA publications.

The codes were added to the NLM's UMLS in 1998.

Table 90. Transactions that involve ABC codes can be tested using an established certification vendor.

Claredi is able to certify use of ABC codes in HIPAA transactions. Claredi provides HIPAA EDI standard transaction testing and certification solutions to help health plans, clearinghouses and providers produce HIPAA-compliant transactions.

As noted above, ABC codes fit into the same insurance forms, data fields, software applications, information systems and business processes as the HCPCS I, II and III code sets, download into existing healthcare information systems and work with commonly used software applications.

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Table 91. ABC codes load easily into HCIT applications. Occasionally a field definition needs to be changed to reflect alphabetic characters.

Medical Professional Systems includes ABC codes in its ABC Remedy® application. Bridges in Medicine loaded ABC codes into its Lytec® practice management system. Oleen, a VISTA implementation vendor, is evaluating deployment ABC codes in VISTA applications used by the Indian Health Service.

Further, in addressing requests for changes to ABC terminology and codes, Alternative Link follows the principles established for the DSMOs. The company openly addresses ABC terminology and code requests, reviews requests in a timely manner, cooperates and communicates with relevant entities, considers relevant viewpoints, evaluates the impact of each change request on U.S. healthcare, maintains a national perspective and conforms to the law.[288]

Thus, ABC codes are uniform and consistent with other standards adopted under this part and, as appropriate, with other private and public sector health data standards.

§162.940(a)(1)(iv) Have low additional development and implementation costs relative to the benefits of using the standard.[289]

ABC codes have low additional development and implementation costs relative to the benefits of their use as a standard.

As noted above, the structure of ABC codes is uniform and consistent with the structure of CPT and HCPCS II codes, so that existing insurance forms, data fields, software applications, information systems and business processes easily accommodate them.

However, ABC codes deliver greater unique benefits that cannot be derived from use of CPT and HCPCS II codes alone. For example, ABC codes allow health industry stakeholders to address the care delivered by IHCPs in a manner that supports state law—a capability heretofore unattainable.

Table 92. Before ABC codes, IHC programs were seldom profitable. ABC codes support essential management processes such as forecasting, hiring, managing inventory and measuring revenues, costs and profitability.

A West Coast health system with a business unit focused on IHC is using ABC codes to develop fees for CAM interventions and to track the cost-effectiveness of care in relation to conventional medical programs. The business unit is planning to deploy ABC codes to better support the financing, administration and delivery of integrative health interventions.

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As noted above, the population of IHCPs is more than quadruple the population of MDs. Public demand for IHCPs is greater than public demand for PCPs. For example, the number of patient visits to CAM practitioners is more than 60% higher than the number of visits to PCPs. The market for CAM interventions has a CAGR of about 14.2% versus about 9% for PCPs.[290] [291] [292] Thus, inefficiencies and resulting cost burdens created by the gap in the HIPAA standard are creating increasing financial, administrative and care delivery pressures on healthcare providers, health plans, healthcare clearinghouses and other health industry stakeholders.

These entities face modest to moderate implementation costs in adopting ABC codes. They may need to secure management concurrence; educate a project champion and then relevant personnel about ABC codes; develop code set implementation strategies and plans; ensure the codes are properly downloaded into applicable HCIT applications and systems; qualify and validate those HCIT applications and systems; reengineer or eliminate burdensome business processes that served as stop gap measures in the absence of the codes, re-qualify any reengineered processes; and modify reporting systems and processes to make full use of code set functionality in managing care, claims and outcomes. The cost and benefits of these steps vary by organization and were addressed in earlier sections of the report. In any case, implementation of ABC codes is most often addressed as an extension of HIPAA compliance initiatives; a part of HCIT leveraging business process reengineering plans; or a part of consumer-driven health plan deployments. It is seldom addressed as a standalone project and seldom presents an isolated cost.

Table 93. ABC codes work seamlessly with CPT and HCPCS II codes to support EDI.

A leading commercial health plan is deploying ABC codes as part of a nationwide effort to standardize, automate and consolidate its claims management processes.[293]

Because ABC codes are most often deployed as part of BPR, the fully loaded costs that would apply to a freestanding ABC code deployment initiative are more appropriately allocated to BPR.

Implemented on a freestanding basis or in conjunction with HIPAA-related business process improvements, ABC codes offer both measurable and immeasurable benefits, including improvements in individual and public health, business and industry efficiencies and socioeconomic recovery. The specific drivers of these benefits, e.g. improvements in economic and health outcomes, were highlighted above.

Table 94. Health plans are adapting to consumer demand for choice in healthcare providers, whether supported by CDHPs, HSAs, MSAs, FSAs, HRAs, or expansion of benefits in older plans.

A leading Blue Cross/Blue Shield plan is planning to deploy ABC codes as part of its benefit plan for its own employees and then extend the benefit to other beneficiaries.[294]

In summary, the use of ABC codes in combination with existing HIPAA code sets provides health industry stakeholders with the ability to make health policy decisions on the basis of more complete, accurate and precise information. It is allowing stakeholders to assess, and take action based on, the relative safety, efficacy, cost-advantages and compatibility of conventional, complementary and alternative modes of care, whether delivered by MDs or IHCPs.

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A predictable result of this is concurrent improvements in healthcare access, quality and cost-containment—three critical endpoints difficult to achieve in combination.

In light of these favorable effects on the well-being of Americans and the efficiency and effectiveness of the U.S. healthcare system—whether implemented as part of HIPAA compliance efforts or in isolation—ABC codes have low additional development and implementation costs relative to the benefits of their use as a standard.

§162.940(a)(1)(v) Be supported by an ANSI-accredited standard setting organization (SSO) or other private or public organization that will ensure continuity and efficient updating of the standard over time.[295]

ABC codes are supported by ANSI-accredited SSOs, as well as other private and public organizations. This fact will ensure continuity and efficient updating of the code set over time.

ABC codes were voted into ANSI X12N 004022 and are included in the ANSI ASC X12N 004050 draft implementation guides. Evidence of this is included as Exhibit Z. The newly updated version of this document is under final review and will reference "ABC codes" rather than "complementary, alternative or holistic procedure code strings" (the latter being terms that Alternative Link used in 1998 when the codes were first added to the X12 standard, version 004022).

As noted above, ABC codes fit into the same insurance forms, data fields, software applications, information systems and business processes as HCPCS codes.

ABC codes are a registered vocabulary of HL7, were favorably reviewed in several articles in AHIMA and DISA publications, and are included in the UMLS.

Leading nursing terminology developers and state and national associations support terminology development through Alternative Link and the Foundation for Integrative Healthcare (FIHC, a non-profit 501(c)3 organization).

Among these are

- the developers of the Nursing Intervention Classification Scheme, the Home Health Care Classification System and the Omaha System Intervention Scheme;
- the American Nurses Association (which, as noted above, represents an estimated 2.7 million registered nurses);
- the National Association of Clinical Nurse Specialists (which represents more than 48 clinical nurse specialties and more than 60,000 CNSs);
- three national acupuncture organizations (representing approximately 5,000 acupuncturists); and
- state chiropractic associations (representing approximately 60,000 chiropractors).

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Updating of ABC codes is assured by a publicly available ***ABC Terminology and Code Request Form*** and an open coding process described in Alternative Link's publications and web site (http://www.alternativelink.com/ali/abc_codes/code_request.asp).

The terminology and code development and maintenance process is inclusive. It already supports nearly two dozen types of IHCPs. The terminology and codes are being expanded to reflect emerging practices of other practitioners—such as allied and public health practitioners—with priority given to those involved in supporting or delivering healthcare to large, disenfranchised and/or "at risk" populations.

Changes, additions and retirements to ABC terminology and codes may be requested by anyone. These requests are systematically reviewed by SMEs with backgrounds in health services research, IHC specialties, terminology and nomenclature development, coding, billing, insurance reimbursement, public health and other disciplines.[296]

Based on the terminology suggested by terminology and code requestors, Alternative Link conducts crosswalks to assure unique code assignment and enters a corresponding string of unique alphabetic characters into a proprietary database and HCIT application through which ABC codes are developed, maintained and disseminated.

Alternative Link offers updates on its codes and terminology and code development and maintenance processes to the DSMOs, to the NCVHS and to HHS operating units.

The Company has provided comprehensive information on ABC codes and their oversight to the following entities:

- American National Standard Institute Accredited Standards Committee X12N
- Dental Content Committee of the American Dental Association
- Health Level Seven
- National Council for Prescription Drug Programs
- National Uniform Billing Committee
- National Uniform Claim Committee
- Blue Cross/Blue Shield Association
- America's Health Insurance Plans
- Centers for Medicare & Medicaid Services
- National Committee on Vital and Health Statistics
- National Library of Medicine
- National Institutes of Health
- Office of Minority Health
- Agency for Healthcare Research and Quality
- Veterans Administration
- Department of Defense
- Office of Personnel Management
- American Medical Association

Thus, ABC codes are already supported by an ANSI-accredited standard-setting organization (SSO) and other private or public organization that will ensure continuity and efficient updating of the standard over time.

Because the codes are designed to support not only HIPAA requirements, but also the consumer-centric and interoperable NHII to improve research, management and commerce, ABC codes will be supported by a broader range of SSOs.

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§162.940(a)(1)(vi) Have timely development, testing, implementation and updating procedures to achieve administrative simplification benefits faster.[297]

ABC codes have timely development, testing, implementation and updating procedures to achieve administrative simplification benefits faster. The development, testing, implementation and updating procedures for ABC codes have been accepted by the National Library of Medicine, Unified Medical Language System.[298]

These procedures were described in the exception application submitted by Alternative Link and the FIHC to Secretary Tommy G. Thompson on October 8, 2002, and approved on January 16, 2003.

Regarding ***development***, Alternative Link's open terminology and coding development and maintenance process was described in the exception request of October 8, 2003, and is updated, as necessary, in Alternative Link's annual publications.

Under the latest business process controls, Alternative Link assigns ABC codes based on the official terminology and nomenclature for IHC practices in coordination with

1. FIHC,
2. the National Association of Clinical Nurse Specialists (NACNS),
3. the developers of the Nursing Intervention Classification System (NIC), Omaha System Intervention Scheme (Omaha), Home Health Care Classification System (HHCC); and/or
4. other practitioner associations and other stakeholders relevant to the targeted area of terminology and code development.

Alternative Link's terminology and code development and maintenance professionals have two areas of focus.

First, they are responsible for

- processing ABC Terminology and Code Request Forms in accordance with standard operating procedures;
- testing any resulting ABC codes against valid requestor and SME acceptance criteria; and
- developing corresponding practitioner identifiers (used as code modifiers), relative values, legal scope of practice information and training standards.

Table 95. Code development is initiated through 1) ABC Terminology and Code Request Forms and 2) characterizations of emerging markets such as end of life care, obesity and weight management, genetic profiling and counseling, abstinence and sex education, and culturally competent care.

Guidelines for submitting the ***ABC Terminology and Code Request Form*** are available at http://www.alternativelink.com/ali/abc_codes/code_request.asp and in ABC coding-related publications. Anyone may submit a request form.

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For those terminology and code developments associated with ***ABC Terminology and Code Request Forms***, Alternative Link's terminology and coding professionals ensure proper development of ***expanded definitions*** for the care that is to be represented by coding through a collaborative process with relevant associations and SMEs.

With expanded definitions established, the professionals then complete ***concept crosswalks*** to CPT and HCPCS II code sets to preclude the development of duplicate or partially overlapping representations of interventions. If necessary, the professionals work with the practitioner associations to refine the expanded definitions to avoid duplications and overlaps.

Once non-duplication of concepts is assured (e.g., by using either Alternative Link's proprietary terminology and code development and maintenance application or those offered by Apelon and other qualified vendors),[299] the professionals establish a hierarchic description of the intervention and assign a corresponding 5-character ABC code. These descriptions and codes are marked as tentative within the Company's proprietary or outsourced terminology and code development and maintenance applications.

Table 96. ABC codes evolve from unique clinical and administrative concepts.

The hierarchic structure of ABC code **BFBAK** is illustrated in Exhibit F, along with an expanded definition. Expanded definitions are available electronically in conjunction with the ABC code set.

The proposed ABC terminology and codes are immediately returned to the requestor and relevant SMEs for their concurrence. SME reviews are managed through a proprietary process and, in time, may be managed through outsourced applications such as Apelon's Terminology Development Environment.[300]

Once concurrence is received or suggested changes made and revalidated, the terminology and coding is relabeled as ***live*** within the proprietary terminology and code development and maintenance application or, in time, in outsourced applications such as Apelon's Distributed Terminology System (DTS) Vocabulary Server for deployment (which helps deploy vocabularies within integrated healthcare applications such as real time decision support systems, order-entry systems, and interface engines).

With the timing accelerated by proprietary or validated and outsourced HCIT applications, Alternative Link's technical personnel can complete terminology crosswalks and validate code assignments within approximately 40 days of receipt of request forms.

Table 97. Timely code development is supported by HCIT applications.

The request for codes for Christian Science practitioners was submitted on July 23, 2002. Code assignment was completed by August 30, 2002—about 30 business days after the code request was submitted.

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Second, ABC terminology and code development professionals are responsible for

- identifying emerging fields of healthcare (e.g., end of life care, weight management, genetic profiling and counseling, abstinence and sex education, culturally competent care);
- overseeing the characterization of those fields to identify rapidly emerging gaps in terminologies and codes; and
- developing gap-filling codes on a Just-in-Time (JIT) basis.

To support coding initiatives, Alternative Link professionals hire SMEs with specialized competencies essential to understanding and identifying specific interventions and practitioner types associated with the emerging areas of care.

Table 98. Characterizations of emerging healthcare fields support timely development of ABC terminology and codes.

To support a leading commercial health plan in development of terminology and coding related to a new benefit plan for palliative care, Alternative Link hired a prominent RN/PhD to research and characterize the field of palliative care.

The RN/PhD identified categories of care, key interventions and critical caregivers, as well as their respective roles in patient diagnosis and treatment.

After review and editing by other SMEs, this overview of palliative care was concurrently submitted to the health plan and Alternative Link's terminology and code development and maintenance professionals.

Working in coordination, the health plan and Alternative Link are ensuring

1. the design of the health plan's new palliative care benefit reflects the ***state of the art*** in palliative care, and
2. that this benefit plan continues to be supported by complete, accurate and precise codes for all key practitioner types and palliative care practices.

Alternative Link is pursing similar terminology and code development strategies for weight management, genetic profiling and counseling, abstinence and sex education, culturally competent care, and other fields.

With concurrence from FIHC, NACNS and/or other the relevant practitioner associations or health industry stakeholders, Alternative Link provides notices of terminology and code additions on a quarterly basis and issues full ABC code set version updates on an annual basis.

With advances in internal and outsourced HCIT system capabilities such as those provided by Apelon, Alternative Link anticipates near "real time" terminology and code implementations and updates as soon as the beginning of Q2 2005.

To support administrative simplification in the U.S. healthcare system, ABC codes are available in hard copy, ASCII data file and PDF formats, as well as in Alternative Link's HealthIntel Database.

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The HealthIntel Database includes not only the ABC codes and practitioner identifiers, but also data elements that enhance the code set's value. These elements are not proposed as part of the HIPAA standards. The elements already include relative values, legal scope of practice information and training standards to support determinations of the legality of care on a per intervention, per practitioner and per state basis. They will soon be linked to information on clinical efficacy and cost-effectiveness through strategic initiatives with Natural Standard and others.[301] [302] The HealthIntel Database is in a SQL System 7.0/2000 format. It will be accessible near "real time" via a "log in" web service as soon as the beginning of Q2 2005.

The hard copy version of the ABC code set is published by FedEx Kinko's on a just-in-time (JIT) basis as "ABC Coding Manual for Integrative Healthcare." This coding manual can be purchased online[303] through Alternative Link and its distribution partners.[304]

Portions of the ABC code set are included in the ChiroCode Institute's ChiroCode DeskBook[305] which is used by an estimated 30,000 chiropractors and chiropractic trading partners each year.

The value of the coding manual is enhanced by "Relative Values for Integrative Healthcare Using ABC Codes," published by RVSI.[306] This publication is available for purchase through both Alternative Link's web site (http://shop.alternativelink.com/) and that of RVSI (http://www.rvsdata.com/ps2.html).

Administrative simplification is further supported by more than 600 versions of the "Practitioner's Guide to Billable Interventions Using ABC Codes." Each practitioner's guide lists only those ABC coded interventions an IHCP can legally deliver in a specified state, such as an acupuncturist in Maryland, based on statutes, administrative regulations and case law. The guides are supplemented with a list of codes that reflect care that can be delivered with additional practitioner training.

As noted above, electronic use of ABC codes is supported by the ANSI ASC X12 004050 draft implementation guides. Reliance on these guides supports administrative simplification by allowing for use of ABC codes in HIPAA transactions. Certification of HIPAA transactions using ABC codes can be secured through Claredi.[307]

Administrative simplification is further supported by Alternative Link's line of consulting services. The Company provides educational, research and analytical and management consulting services to facilitate benefit plan design, managed care and provider contracting, utilization and clinical practice management, claims processing, outcomes research and actuarial analyses using ABC codes.

As a starting point in supporting code set adoption to help covered entities and their trading partners achieve administrative simplification, Alternative Link provides training to practitioner associations, HCIT user groups and others on the functionality and deployment of ABC codes.

Alternative Link also conducts research and analytical projects to help providers, health plans and clearinghouses achieve the benefits of administrative simplification more rapidly.

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Table 99: ABC codes help code set users achieve administrative simplification by improving data collection, facilitating more effective communication and allowing manual business processes to be automated.

For the Medicare Advantage and related senior plans in New Mexico, Alternative Link successfully
1. developed patient encounter forms for contracted IHCPs,
2. calculated the billing rate differential between CPT and ABC codes, and
3. supported proposal development and contract negotiations with Ardent Lovelace Sandia.

With these documents, Bridges in Medicine was able to reengineer its practice management processes to
1. simplify administrative procedures,
2. capture more meaningful data on delivered care and its outcomes, and
3. automate previously manual business processes.

Ardent Lovelace Sandia was able to expand its benefit plan for seniors to include more IHC interventions.[308]

Thus, ABC codes have timely development, testing, implementation and updating procedures to achieve administrative simplification benefits faster.

§162.940(a)(1)(vii) Be technologically independent of the computer platforms and transmission protocols used in electronic health transactions, except when they are explicitly part of the standard.[309]

ABC codes are technologically independent of the computer platforms and transmission protocols used in electronic health transactions, except when they are explicitly part of the standard.

ABC codes are housed in a HealthIntel Database using a SQL Server Version 7.0/2000 format. HealthIntel Database contents, such as ABC codes, practitioner identifiers (used as code modifiers), relative values, legal scope of practice information and training standards can be delivered in a CSV (comma separated values) format, a Word format, an Excel format, an Access format, an ASCII data file format and a broad range of other formats.

The codes are developed, maintained and distributed independently, but are supported by ANSI ASC X12 implementation guides.

The ANSI ASC X12 004050 implementation guides include *qualifiers* to indicate that ABC codes will follow in a transmission. Covered entities, trading partners and business associates can use these qualifiers immediately, in anticipation of updates to HIPAA.

Alternative Link offers a "Companion Document Supporting the Use of ABC Codes in Transactions Mandated Under HIPAA." (Please refer to Exhibit G.)

Alternative Link provides the Companion Document at no cost on the Company's web site (www.AlternativeLink.com).

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The HealthIntel Database elements other than ABC codes and practitioner identifiers offer functionality necessary for the NHII and supportive of the HIPAA transaction and code set standards. (As noted above, these elements are not being proposed as part of the HIPAA standards.) The database includes information on the legality of IHC when delivered by a broad range of caregivers in each of the 50 United States and the District of Columbia. These database elements extend the functionality of ABC codes beyond that of HCPCS; however, the other database elements are not essential to the basic HIPAA-related functionality inherent in ABC codes. That is, ABC codes can stand alone as a HIPAA-compliant code set, independent of the other database elements Alternative Link has compiled to support improvements in healthcare research, management and commerce.

ABC codes are typically acquired by providers, health plans and healthcare clearinghouses in hard copy publications, ASCII data files and PDF formats. The codes are technologically independent of the computer platforms and transmission protocols used in electronic health transactions, except for the aforementioned ASC X12N qualifiers. With those qualifiers, the codes can be used electronically. Without them, the codes can be used in standard paper claim forms or data fields, software applications, information systems and business processes that do not depend on the qualifiers.

§162.940(a)(1)(viii) Be precise, unambiguous, and as simple as possible.[310]

ABC codes are precise, unambiguous, and as simple as possible.

ABC codes are ***precise***. For example, the CPT code set offers 4 codes that describe chiropractic manipulation. These are based on body regions only. In comparison, the ABC code set reflects 35 chiropractic adjustments and related treatments.

ABC codes are ***unambiguous***. Each character position conveys a specific type of information. Each alpha symbol has a specific meaning. Each meaning is echoed in the procedure description, as illustrated in Exhibit F.

ABC codes are ***simple***. As noted above, they include 5-character representations of services or supplies delivered by IHCPs. The hierarchic structure of the codes helps users more easily identify the type of care the codes reflect, just using the letters in the codes. For example, the letters A, A and B in character positions 1, 2 and 3 (i.e., AAB_ _) always represent an office visit by a current client.

Also as previously noted, ABC codes are modified by two alphanumeric characters that serve to identify the practitioner type.

As previously addressed, the 5-character alphabetic intervention identifier, and the 2-character alphanumeric practitioner identifier that serves as a code modifier, when paired with the state code on a claim form, can be read by a software application to determine whether a particular intervention is legal in the noted state when delivered by a particular practitioner type.

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Table 100. ChiroCode Institute's DeskBook—a coding manual for chiropractors—incorporated ABC codes to give chiropractors more complete, accurate and precise ways to reflect the care they delivered.

Because ABC codes are precise, unambiguous and simple, ChiroCode Institute has included the codes in its ChiroCode DeskBook.

ChiroCode is a recognized leader in providing business resources to chiropractors to help these practitioners

1. better understand current coding, reimbursement and compliance issues;
2. identify, describe and report current diagnoses, procedures, and supplies;
3. evaluate and determine their own fees for appropriate reimbursement; and
4. pursue proper payment.

This year, ChiroCode has sold about 10,000 DeskBooks that include ABC codes.

These points and prior comments establish that ABC codes are precise, unambiguous, and as simple as possible.

§162.940(a)(1)(ix) Result in minimum data collection and paperwork burdens on users.[311]

The ABC codes result in minimum data collection and paperwork burdens on users.

ABC codes result in minimum ***data collection*** burdens on users. Precise coding supports automated data warehousing, querying, analytical and reporting capabilities. This reduces the need for manual data collection and paper record review to perform the kinds of actuarial analyses needed for benefit plan design, utilization and clinical practice management, development of claim edit/scrub rule engines and outcomes research.

ABC codes result in ***minimum paperwork burdens*** on users. The aforementioned design, functionality and benefits of ABC codes reduce the need for labor intensive and paperwork-laden steps that would otherwise be necessary in documenting and managing care, claims and outcomes for integrative health interventions.

These unnecessary steps could include (but are not limited to) the following:

- General communications among providers and payors
- Inquiries regarding claim payments, claims status, credentialing status, eligibility and benefits, fee schedules, precertifications and referrals
- Maintenance of provider data
- Requests for overpayment recovery and remittance
- Sending of benefits rosters, capitated lists, credentialing decision letters, credentialing/recredentialing information, information/documentation for claims processing, member rosters, payments, explanations of benefits and provider directories
- Verification of the legality, clinical necessity and cost-effectiveness of care

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ABC codes and the expanded definitions associated with the codes are sufficiently precise to avoid the need for supplemental written communications to establish the nature of the delivered care, its legality, its clinical necessity and its cost-effectiveness.[312]

In contrast, CPT and HCPCS II codes typically use less granular language in describing IHC interventions, so the assigned codes may not effectively communicate the nature of delivered care.

Further, the HCPCS code sets leave thousands of IHC interventions uncoded so that only manual and paperwork-laden processes can be used to support the management, financing and delivery of care.

Thus, ABC codes result in minimum data collection and paperwork burdens on users.

§162.940(a)(1)(x) Incorporate flexibility to adapt more easily to changes in the healthcare infrastructure (such as new services, organizations and provider types) and information technology.[313]

ABC codes incorporate flexibility to adapt more easily to changes in the healthcare infrastructure (such as new services, organizations and provider types) and information technology.

ABC codes incorporate ***flexibility***. The alphabetic format of the five-character ABC codes allows for more flexibility than the five-character numeric format of CPT codes and the single alphabetic character plus four numeric character format of HCPCS II codes. As noted above, because of its alphabetic structure, the ABC code set can accommodate over 11.8 million new services and supplies. The practitioner identifiers used as code modifiers can accommodate up to 1,296 practitioner types in the first modifier field. Since HIPAA requires five modifier fields, ample character space exists to reflect practitioner types beyond the U.S. market.

The ABC codes provide ample opportunities for new code development. They could, for example, be crosswalked/mapped to ICD-10-PCS codes to make the PCS codes available earlier.[314]

ABC codes ***adapt more easily to changes in the healthcare infrastructure, such as new services, organizations and provider types***. The ABC terminology and code development and maintenance process captures data on emerging technologies, delivery systems and practitioners more quickly than the processes associated with the HCPCS code sets. The ABC processes were designed for speed, specifically to meet this guiding principle. Ongoing terminology development drives code assignment. Ongoing review of state law ensures practitioner-identifying modifiers are added as states grant licensure to new categories of healthcare practitioners. If new healthcare organizations emerge, relevant codes can be assigned on an as needed basis.

Beyond HIPAA, ABC codes support a broad range of goals addressed in the Presidential Executive Order and the HHS NHII initiatives. ABC codes are designed as impartial metrics that help reflect all approaches to care, regardless of their economic and health outcomes. ABC codes support objective evaluations of those outcomes in clinical practice.

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Thus, the interventions described by ABC codes are not subjected to conventional medical technology assessments in the manner described by CPT and HCPCS II code developers.[315] [316] This reduces the time from terminology and code request to code assignment.

In contrast, the subjective technology assessment step used in the CPT and HCPCS II terminology and code development processes do not easily adapt to changes in the healthcare infrastructure, such as new services, organizations and provider types. These assessments may generate biases toward the status quo, e.g., conventional medicine. They may delay coding for emerging approaches to care, new organizations that deliver care and new practitioner types by forcing innovations to fit into a pre-existing paradigm even if that paradigm is not relevant.

Development and maintenance of ABC codes is overseen by an unaffiliated organization rather than a practitioner trade association. IHCPs and practitioner associations have reported greater access to codes through Alternative Link than through the AMA's CPT Editorial Panel and the HCPCS Alpha-numeric Editorial Panel.

ABC codes ***adapt more easily to changes in information technology***. As new information technology emerges, ABC codes can be readily incorporated and/or adapted since they consist of machine-readable alphabetic and alphanumeric characters in a hierarchic structure, supported by freestanding yet potentially linked supplemental data that further support automation (e.g., data on practitioner types, relative values, legal scopes of practice, training standards, clinical efficacy and cost-effectiveness).

In contrast, use of CPT and HCPCS II code sets has led to labor intensive business processes and legacy systems "work around" to handle the lack of coding precision for IHC interventions and IHCPs.

For example, claims reviewers routinely ask for supplemental information from practitioners regarding HCPCS codes. They need more detailed written explanations of medical necessity, legality and economic rationale. The resulting information may be recorded on Post-It notes, notebooks, electronic information silos or other media that do not facilitate automation or adaptation to changes in information technology.

Table 101. HCIT developers and users find ABC codes and related data elements help their clients save money.

A claims repricing organization reported that nearly 15% of its claims are diverted for manual review because of limitations in CPT and HCPCS II code design and related inability to link codes to supporting information on practitioner types, relative values, legal scopes of practice and training standards.

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Thus, ABC codes incorporate flexibility to adapt more easily to changes in the healthcare infrastructure (such as new services, organizations and provider types) and information technology.

§162.940(a)(2) Specifications for the proposed modification.

Alternative Link has established desired specifications for the proposed maintenance of the HIPAA code sets, and seeks designation of ABC codes, in their current form, as a Level IV code set under HCPCS.

Alternative Link also seeks an extension of availability of ABC codes under 45 CFR 162.940 through October 16, 2007, or until the code set becomes mandatory under HIPAA, whichever is longer. This will support commercial use of the codes in HIPAA transactions and other applications while covered entities and their trading partners implement and validate them as part of the HIPAA code sets.

ABC codes are immediately available in 1) ASCII[317] data files, 2) hard copy publications, and 3) PDF formats, as well as in SQL Server Version 7.0/2000 format.

The ASCII data files for ABC codes can be loaded directly into existing practice management systems (PMSs) and other HCIT applications, just as HCPCS ASCII version updates can be loaded directly into these systems and applications.

In some software applications and information systems, data field character recognition capabilities may need to be expanded from numeric characters to alphanumeric characters.

Alternative Link plans to discontinue systematic collection of statements of interest from those entities that desire to use the codes, upon incorporation of ABC codes into the HIPAA code sets.

The Company will continue to collect contact information from entities that desire to be included in the ABC code set user database.

Assuming reasonable privacy and security measures are in place within HHS to support anonymity of contacts, as well as protection of their confidential and proprietary information, the user database could be made available to HHS for ongoing assessments of code set interest, implications and value.

Again, Alternative Link seeks naming of ABC codes as a mandatory HIPAA code set, in their current form, under a new Level IV HCPCS designation. Until health industry stakeholders are required to support this code set under HIPAA, an extension of code set availability under 45 CFR 162.940 is requested. This will support controlled deployment of the code set up and down the health industry vertical and across the continuum of care.

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§162.940(a)(3) Testing of the proposed modification

Alternative Link will continue to compile data on the commercial use and cost-benefit of ABC codes both within and beyond HIPAA transactions over the next three years or until HHS names ABC codes a standard.

The Company is focusing on documenting the impact of ABC codes on…
- health plans, healthcare clearinghouses and providers;
- individual patient encounters, treatment paths, and disease or health management programs;
- alternative, complementary and conventional interventions;
- emerging, prevalent and obsolescent healthcare products and services;
- minority/ethnic populations, community health programs and academic research centers.

Assuming reasonable privacy and security measures are in place within HHS to support anonymity of contacts, as well as protection of their confidential and proprietary information, Alternative Link may update HHS on planned deployment of ABC codes and may invite HHS suggestions about approaches that would best support the intent of HIPAA and the NHII.

Alternative Link is prepared to submit the 2005 version of the ABC code set in accordance with industry delivery timetables.

Alternative Link may submit additional deployment tools (such as training presentations and materials) to HHS, in advance of use, and invites HHS suggestions about modifications to these instruments that would better support HHS strategies, operations and/or tactics.

Alternative Link will continue to
1. confirm the HIPAA code set gaps currently and potentially filled by ABC codes;
2. characterize the potential economic and health benefits of filling those gaps;
3. prioritize areas for ABC code set refinement and expansion;
4. identify insurance forms, data fields, software applications, information systems and business processes affected by ABC codes;
5. document any emerging challenges in relation to use of ABC codes in insurance forms, data fields, software applications, information systems and business processes;
6. identify organizations and individuals affected by ABC codes, confirm their training needs, provide basic information online to support self-training, and work with training organizations to facilitate development of more formal training programs;
7. evaluate the effect of ABC codes on individual and public health, business and industry efficiencies and socioeconomic development;
8. continue to evaluate and improve the ***ABC Coding Manual for Integrative Healthcare***, ASCII data files with ABC codes and terminology and/or new publications or media with comparable content and functionality (e.g., ChiroCode Institute's ***ChiroCode DeskBook***);
9. coordinate with RVSI or a comparable entity to continue to evaluate and improve ***Relative Values for Integrative Healthcare Using ABC Codes*** and/or new publications or media with comparable content; and

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10. continue to evaluate and improve the ***Practitioner's Guide to Billable Interventions Using ABC Codes*** series and/or new publications or media with comparable content and functionality to support practitioner compliance with state scope of practice laws and training and licensing requirements.

Alternative Link will support covered entities, trading partners and business associates by making the following resources available:

1. A complete set of ABC codes in hard copy, ASCII data file or PDF format
2. Data elements contained in the HealthIntel Database, in SQL Server Version 7.0/2000 or forthcoming HCIT formats
3. Educational materials on ABC codes, their development, and their use
4. Basic project management guidelines and limited non-technical telephone support to facilitate deployment of ABC codes
5. Lists of SMEs capable of supporting code set implementation efforts.

Alternative Link will extend reasonable effort to compile basic cost-benefit data from deployment sites and will conclude documenting the deployment of the code set when the code set becomes mandatory under HIPAA or when HHS suggests such documentation is no longer necessary, whichever comes first.

§162.940(a)(4) Trading partner concurrences.

Alternative Link has submitted information on more than 10,000 covered entities that have secured rights to use ABC codes in HIPAA transactions by registering their "Statements of Interest" via the Companies web site between January 16 and May 30, 2003.

Among the registrants are individual practitioners, practitioner associations, academic research centers, provider organizations, health plans, third party administrators, administrative service organizations, healthcare clearinghouses, actuarial consultants, self-insured employers, healthcare information technology companies and others. The trading partners of these entities number in the millions.

Assuming the protections noted above are in place, Alternative Link will share with HHS relevant information on deployment of ABC codes, to the degree possible without violating pre-existing non-disclosure agreements.

§162.940(b) Basis for granting an exception.

Alternative Link understands HHS may extend the exception for reasons including those noted below.

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§162.940(b)(1) An assessment of whether the proposed modification demonstrates a significant improvement to the current standard.

ABC codes are essential to the maintenance of the HIPAA code sets, as previously noted in this report and under a separate communication to the Office of the Secretary at HHS.

Through the cost-benefit analyses presented in this document, Alternative Link has demonstrated that incorporation of ABC codes into HCPCS, as a maintenance step, would result in a significant improvement to the current standard.

Alternative Link has provided evidence that ABC codes

1. currently describe the practices of more than 3 million IHCPs who are currently disenfranchised from mainstream healthcare;
2. can be expanded to describe the practices of additional practitioners, as well as new practices in rapidly emerging markets (e.g., palliative care, weight management, genetic profiling and counseling, abstinence and sex education, and culturally competent care);
3. fill a critical gap in the HIPAA standards not addressed by existing code sets or within the expertise of existing coding authorities;
4. support individual and public health, especially for populations subject to disparities in care;
5. address pressing business needs and improve industry efficiencies;
6. help U.S. employers meet bottom line earnings projections; and
7. meet congressional intent under HIPAA.

For these reasons, Alternative Link anticipates that CMS will advise the Office of the Secretary and HHS will determine that the proposed maintenance of HCPCS through deployment of ABC codes would improve the current standard.

§162.940(b)(2) The extent and length of time of the exception.

Alternative Link understands that HHS has the authority to extend the time permitted for use of ABC codes as an exception to the HIPAA code set standards.

Alternative Link has provided compelling evidence that ABC codes add value throughout the health industry, both vertically (along the healthcare supply chain) and horizontally (among covered entities, trading partners and business associates).

Alternative Link has provided previous documentation that shows irregularities, delays and changing requirements in the evaluation of ABC codes. These delays continue to compromise the ability of the codes to deliver optimal value to the U.S. healthcare system. The industry will continue to view ABC codes as an investment risk until they are designated a HIPAA standard. For these reasons, the Company anticipates that HHS will make ABC codes immediately and broadly available to all health industry stakeholders who desire to use the codes from this point forward.

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§162.940(b)(3) Consultation with DSMOs.

Alternative Link understands that HHS will consult with the DSMOs and NCVHS about ABC codes.

The Company

- calls attention the history of communications with the DSMOs and NCVHS about ABC codes and the potential need for some members of the DMSOs and NCVHS to recuse themselves from consideration of ABC codes because of potential conflicts of interest;[318] [319]
- invites review of Exhibit AA regarding the politics and economics of IHC; and
- requests that the HHS Office of the Secretary independently evaluate the information previously provided to the DSMOs and NCVHS about the functionality and benefits of ABC codes in relation to HIPAA and the NHII.

Since the incorporation of ABC codes falls under maintenance rather than modification of the HIPAA standards, HHS can take immediate steps to add ABC codes to HCPCS as requested.

§162.940(c) Secretary's decision on exception.

Alternative Link understands HHS will make a decision on the performance of ABC codes under this exception.

The Company has noted that

- the number of health practitioners who will remain disenfranchised from mainstream healthcare unless ABC codes are made available to them is larger than the number of practitioners served by the HIPAA code sets;
- the HIPAA code set gaps prevent head-to-head comparisons of the economic and health outcomes of conventional, complementary and alternative care, as well as MDs and IHCPs;
- the gaps lead health policymakers to rely on incomplete, inaccurate and imprecise data in formulating solutions to pressing challenges with healthcare access, quality and cost-management; and
- the absence of ABC codes leaves health industry stakeholders with inadequate information to design health insurance benefit plans, establish managed care and provider contracts, manage utilization and clinical practices, process claims, conduct outcomes research and perform actuarial analyses.

As a result of gaps in HIPAA code sets, many health plans have defaulted to capping annual visits or expenditures rather than supporting all clinically necessary, cost-effective and evidence-based care in high demand areas of CAM such as chiropractic and acupuncture benefits. In the absence of ABC codes, disenfranchised practitioners are likely to inadvertently engage in fraudulent billing, as they default to describing their services with ill-fitting HCPCS codes.

ABC codes are particularly relevant to medically underserved populations, as well as individuals for whom conventional healthcare is ineffective or is not an option.

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ABC codes are essential to healthcare research, management and commerce.

This report offers sufficient information to support an immediate HHS decision.

On the basis of the Administrative Procedure Act,[320] no more than a 30-day evaluation is expected and a decision is requested immediately thereafter.

§162.940(c)(1) Exception granted.

Alternative Link seeks HHS concurrence with the legal analysis (provided under separate cover) and a proposal to facilitate deployment of ABC codes within HCPCS, e.g., a contract similar to that of the AMA or ADA with CMS or a public domain licensing agreement similar to that established with SNOMED.

Such a licensing agreement would support public access to ABC codes for up to three years under 45 CFR 162.940 and beyond the date on which use of the codes by covered entities, trading partners and business associates is made mandatory under HIPAA.

Alternative Link recommends HHS
1. preclude other HIPAA coding authorities from developing duplicate terminology and codes in areas served and targeted by ABC codes and
2. direct them to begin harmonization initiatives to ensure the most precise codes available and/or those most valuable under HIPAA and NHII initiatives are maintained under the combined HCPCS code sets.

§162.940(c)(1)(i) The length of time for which the exception applies.

Alternative Link understands HHS will establish the length of time for which the exception continues to apply, if any.

Alternative Link has noted that ABC codes have been subject to irregularities and delays in the DSMO and NCVHS evaluation processes. Alternative Link suggests that, without these delays, the ABC codes could have been named a HIPAA standard prior to the HIPAA transaction and code set compliance date of October 16, 2003.

For this reason, Alternative Link requests no less than a three year extension or the length of time necessary to support available of ABC codes pending their mandated use under HIPAA.

§162.940(c)(1)(ii) The trading partners and geographical areas the Secretary approves testing.

Alternative Link understands HHS may address trading partners and geographical areas approved for continued use of ABC codes.

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The Company

- recommends that all trading partners and geographic regions *nationwide* be allowed to use ABC codes pending the designation of the code set as mandatory under HIPAA; and
- believes the U.S. healthcare system would be served by the broadest possible HHS authorization of interim use of ABC codes among trading partners and across geographical areas, pending the compliance date established for the code set under HIPAA.

§162.940(c)(1)(iii) Any other conditions for approving the exception.

Alternative Link understands HHS may establish other conditions for allowing ABC codes to be used under HIPAA pending their designation as mandatory.

The Company has noted the HCPCS design limitations pointed out by NCVHS in 1993 and has addressed challenges in the HCPCS code development and maintenance processes of HCPCS that could result in incomplete, inaccurate and imprecise codes for IHC, as well as rapidly emerging approaches to care (e.g., care associated with new medical products, genetic profiling and genetic counseling).[321]

Conventional medical terminology and code development processes may not fully support Congressional intent under HIPAA or the Presidential Executive Order associated with the NHII.

The industry needs Alternative Link to act as an impartial body and SSO in relation to IHC.

§162.940(c)(2) Exception denied.

Alternative Link understands HHS may deny the request for designation of ABC codes as a Level IV subset of HCPCS and may deny an extension of the commercial use and testing of ABC codes under 45 CFR 162.940.

If HHS does not authorize the maintenance step and/or does not grant the extension, the Company requests an explanation of the reasons HHS believes these actions would be consistent with congressional intent under HIPAA and Presidential intent in the April 2004 Executive Order regarding development of the NHII.

Alternative Link also anticipates development of an HHS action plan that would ensure objective development of codes for IHCPs who face legal and financial hardships as a result of the gap in HIPAA code sets.[322]

Finally, the Company anticipates HHS will continue to monitor the evaluation processes for ABC codes.

Alternative Link has provided compelling rationale for incorporating ABC codes into HCPCS, as a maintenance step, and relying on 45 CFR 162.940 to ensure availability of ABC codes pending a forthcoming mandatory compliance date for code set use under HIPAA.

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§162.940(d) Organization's report on test results.

Alternative Link views this report under 45 CFR 162.940 as voluntary since ABC codes support maintenance rather than modification of the HIPAA standards.

The Company has relied on cost-benefit data developed by CMS, WEDI, RAND and other well respected organizations to ensure this report is viewed as impartial. Alternative Link has supplemented their data with data from demonstration sites.

The Company calls attention to the CMS "Impact Analysis" that points out the net benefits of HIPAA standards would not be expected to accrue until the fourth year of deployment and that evaluation of a standard in isolation is inappropriate since cost-savings and benefits result from synergistic effects among the standards and their users. Alternative Link believes its demonstration sites have nonetheless documented the cost-benefit of ABC codes in HIPAA transactions and other applications associated with research, management and manual commerce, as well as the NHII.

§162.940(e) Extension allowed.

Alternative Link understands that, since this report has been submitted in accordance with § 162.940(d) (Organization's report on test results), HHS may grant an extension to the period granted for the exception.

Alternative Link is confident that the information provided to date warrants designation of ABC codes as a HIPAA standard.

The Company anticipates HHS will designate the code set as such and support its broadest possibility availability within the public domain.

Conclusion

The gap in HIPAA code set standards exists because the HIPAA code sets do not adequately reflect IHC interventions.

The design of the HIPAA code sets does not support mapping to data elements essential in supporting management care, claims and outcomes delivered by IHCPs.

Finally, the current HCPCS code development and maintenance processes are not designed to assign codes to IHC interventions in a timely and objective fashion.

Thus, the HIPAA standard has gaps that prevent it from fully serving the industry's needs.

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Without the detailed and structured coding offered by ABC codes, the industry is forced to
1. use incomplete, inaccurate and imprecise codes that do not directly reflect IHC interventions;
2. manually adjudicate claims, even if those claims are submitted electronically; and
3. limit access to IHC interventions.

The first circumstance (use of imprecise codes) results in a loss of information needed to efficiently and effectively manage care, claims and outcomes. The point of codes and code sets is to describe interventions in a manner that supports administrative simplification, claims payment and public health. Imprecise codes result in a relatively useless pool of data and therefore do not accomplish desired HIPAA endpoints.

Use of inaccurate codes (that describe only remotely related interventions) results in erroneous data that undermines the reliability of healthcare information, compromises actuarial analyses and—perhaps worse—promulgates fraud and abuse (e.g., illegal use of codes).[323]

Use of no codes undermines the administrative simplification objectives of HIPAA. It also results in reliance by health policymakers on incomplete, inaccurate and imprecise data. This could result in policies that compromise individual and public health, business and industry efficiencies and socioeconomic development.

The second circumstance (intervening manually to adjudicate claims) undermines the very purpose of standardized transactions and code sets and may compromise patient privacy.

The third circumstance (limiting access to IHC) may be illegal. It may
- disenfranchise IHCPs from the benefits of administrative simplification,
- create patient privacy challenges by placing patient data outside the protections afforded to electronic information, and
- compromise efficiencies that could be achieved if the healthcare system could capture services from this category of practitioners as part of its efforts to support cost-effective and evidence-based care.

Just as thousands of codes are needed to adequately describe the interventions performed by conventional MDs, thousands of ABC codes are needed to adequately describe the interventions performed by dozens of categories of IHCPs. MDs receive broad and specialized training in allopathic medicine. These are reflected in HCPCS codes. Licensed IHCPs also receive broad and specialized training in their fields. This training is reflected in ABC codes, but is not reflected in the existing HIPAA code sets.

Thus, ABC codes describe interventions not otherwise described. They serve practitioners not otherwise served. They ensure objectivity not otherwise assured. They capture data and generate critical insight otherwise lost. They are market-ready. They are needed now.

Deployment of ABC codes will reduce insurance claims transaction costs by more than fourfold simply by supporting the conversion of manual and partially automated business processes to electronic processes.

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More importantly, the ABC code set offers an estimated $50 billion net benefit to U.S. healthcare.

In addition to offering this administrative simplification and cost-savings under HIPAA, as noted in Exhibits K, Q and R, ABC codes can help

1. improve the NHII, so more Americans gain access to the right care in the right place at the right time, at a rational cost;
2. stabilize America's deteriorating healthcare system; and
3. meet key goals established in the HHS 5-year strategic plan.

Alternative Link will continue the commercial rollout and cost-benefit evaluation of ABC codes in HIPAA transactions. However, Alternative Link seeks an immediate recommendation from CMS to the Secretary of HHS in support of the naming of ABC codes as a Level IV subset of HCPCS.[324]

Alternative Link looks forward to a favorable decision.

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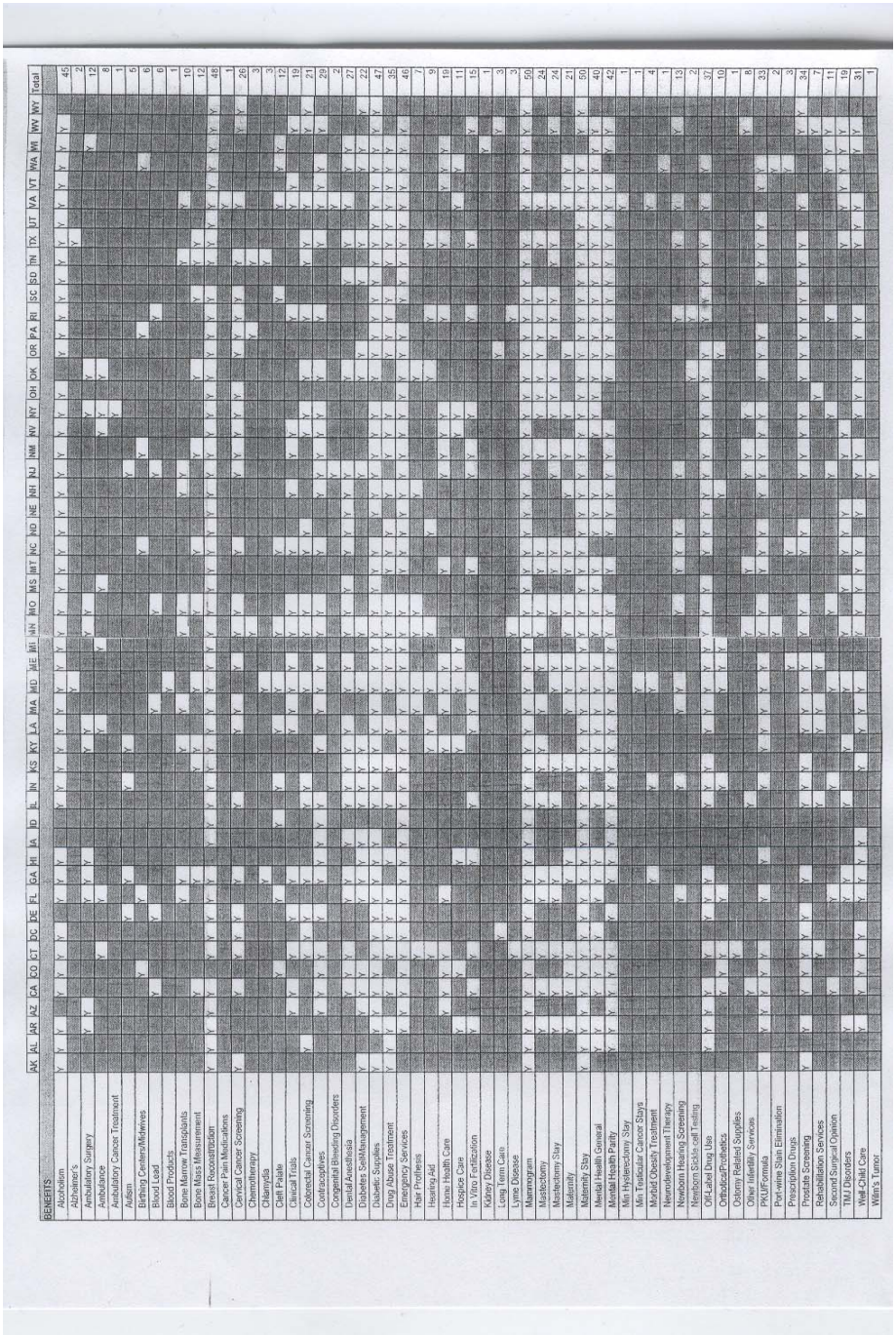
EXHIBIT A – HEALTH INSURANCE MANDATES VARY BY STATE

The chart below demonstrates the health insurance mandates in the United States[325].

Legend: Y - Mandated - Not Mandated


BENEFITS
AK AL AR AZ CA CO CT DC DE FL GA HI IA ID IL IN KS KY LA MA MD ME MI MN MO MS MT NC ND NE NH NJ NM NV NY OH OK OR PA RI SC SD TN TX UT VA VT WA WI WV WY Total
Alcoholism 45
Alzheimer's 2
Ambulatory Surgery 12
Ambulance 8
Ambulatory Cancer Treatment 1
Autism 5
Birthing Centers/Midwives 6
Blood Lead 6
Blood Products 1
Bone Marrow Transplants 10
Bone Mass Measurement 12
Breast Reconstruction 48
Cancer Pain Medications 1
Cervical Cancer Screening 26
Chemotherapy 3
Chlamydia 12
Cleft Palate 19
Clinical Trials 21
Colorectal Cancer Screening 29
Contraceptives 2
Congenital Bleeding Disorders 27
Dental Anesthesia 22
Diabetes Self-Management 47
Diabetic Supplies 35
Drug Abuse Treatment 46
Emergency Services 7
Hair Prosthesis 9
Hearing Aid 19
Home Health Care 11
Hospice Care 15
In Vitro Fertilization 1
Kidney Disease 3
Long Term Care 59
Lyme Disease 24
Mammogram 24
Mastectomy 21
Maternity Stay 59
Mental Health General 40
Mental Health Parity 42
Min Hysterectomy Stay 1
Min Testicular Cancer Stays 4
Morbid Obesity Treatment 1
Neurodevelopment Therapy 13
Newborn Hearing Screening 2
Newborn Sickle cell Testing 37
Off-Label Drug Use 10
Orthotics/Prosthetics 1
Osteoporosis Related Supplies 8
Other Infertility Services 33
PKU Formula 2
Post-mine Stem Elimination 3
Prescription Drugs 34
Prostate Screening 7
Rehabilitation Services 11
Second Surgical Opinion 19
TMJ Disorders 31
Well-Child Care 1
Wilm's Tumor

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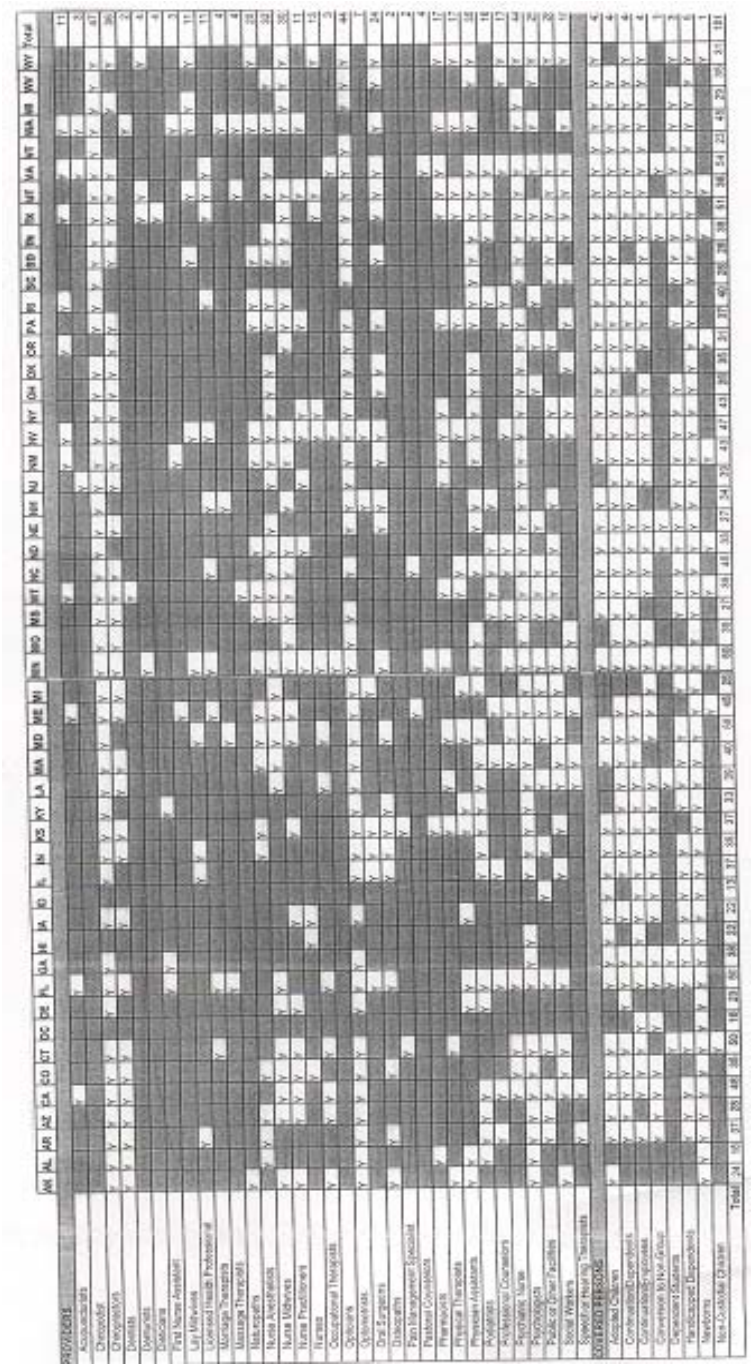

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EXHIBIT B – MANDATES ARE ESTABLISHED WITHOUT ADEQUATE EVIDENCE OF ECONOMIC AND HEALTH OUTCOMES

amednews.com
THE NEWSPAPER FOR AMERICA'S PHYSICIANS

PROFESSIONAL ISSUES

Physician groups brace for allied scope-of-practice incursion

Medical associations gear up for a slew of state legislation next year that seeks to give nonphysicians broader scopes of practice.

By Jay Greene, *AMNews* staff. Dec. 11, 2000.

Medical associations battling scope-of-practice intrusions by nonphysicians finally are beginning to understand what professional athletes know. There is no off-season.

Whether training for athletics or garnering public and legislative support to fight proposed scope-of-practice expansions for nonphysicians, doctors are fighting year-round to keep up with the competition.

Starting in January 2001 in dozens of state legislatures, allied health practitioners -- including optometrists, psychologists, dentists, audiologists and advanced-practice nurses -- are expected to introduce hundreds of bills that would give them independent practice or prescribing rights.

During the legislative off-season -- those months between sessions -- state medical associations in Georgia, California and Louisiana have been reminding lawmakers of the difference between four years of medical school, coupled with at least three years of residency training, and the less rigorous educational and training demands for nonphysicians.

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"In Georgia we will see about the same number of bills ... regarding prescribing issues and independent practice rights," said David Cook, legislative director with the Medical Assn. of Georgia. "We feel we are in a much better position going into this session than in previous years."

During the past year, the Georgia medical society has done a direct mail campaign to explain scope-of-practice issues to patients, Cook said. "When we talk to legislators about our opposition to bills they see it as turf battles [with allieds]. But when a patient writes, legislators see it as a patient care issue. Minds are changed."

To combat an onslaught of expected legislation, medical groups employ two main lobbying strategies, depending on the bill, the legislative history and existing political support.

The more conventional first option is: Spend money, lobby hard, work with national medical associations and take the approach of "see bill, kill bill" in committee. The second option, one that is being used increasingly to combat onerous scope-of-practice bills, is to negotiate with the opposition before the bill is introduced to get the best possible deal, experts say.

"We are a little more aggressive than other states," Cook said. "We compromised on several bills last year [optometry and pharmacy], but now we feel they are going too far. If we get beat, we get beat. We are not going to negotiate away good patient care."

A case study

In California -- long recognized as a bellwether for medical scope-of-practice intrusions -- a controversial compromise bill that greatly expands the scope of optometrists' practice goes into effect in January 2001.

But the compromise split the ophthalmology community.

Robert Penner, MD, president of the California Academy of Ophthalmology, agreed to help write the bill with the California Optometric Assn. because the

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academy felt it would be the best way to minimize inevitable changes and do as little harm to patients as possible.

Mark Mannis, MD, professor of ophthalmology at the University of California, Davis, School of Medicine, supported the compromise approach, primarily because legislative leaders had ordered it, but he feels the bill went too far and endangers patients.

"I am extremely concerned with the bill," Dr. Mannis said. "It gives optometrists, who are not trained in medicine and have very limited exposure to clinical pathology, the right to practice, just short of surgery, the full gamut of ophthalmologic care. ... It lowers the bar of quality for the public in this state."

The bill allows optometrists to diagnose and treat specific eye diseases and prescribe various antibiotics and narcotics. While one of the California bill's provisions allows "certified" optometrists to treat primary open angle glaucoma, that certification, and other requirements, makes the bill more restrictive than similar measures in 45 other states, Dr. Penner said. Certification includes 24 hours of additional education and the completion of a two-year, 50-case collaborative partnership with an ophthalmologist.

"With the exception of glaucoma treatment, we went from having the most restrictive law on optometry to having a bill just about like every state," said Bob McElderry, associate director of legislation with the California Medical Assn., which opposed the bill. "This shows what happens when societies don't band together."

But Dr. Penner said the ophthalmologists group was in a no-win situation. After failed attempts in 1994 and 1995, optometrists had legislative support for the scope bill in 2000. During the past five years the optometrists group had vastly outspent the academy on lobbying efforts to expand their scope. The only option left open to the ophthalmologists was to seek a compromise, he said.

"The academy attempted to alert and activate its membership to the probable legislative battles that would occur," Dr. Penner said. "It was very difficult to

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arouse the rank and file membership" into giving enough money for a stronger lobbying effort.

While two states this year -- California and Utah -- struck legislative compromises with optometrists, 18 optometric bills were successfully defeated with the support of national medical associations, including the AMA, said Bob Palmer, legislative director with the American Academy of Ophthalmology.

"We are becoming more politically aware of how to present cases to regulators and legislators," he said. "As a result, we are having more success in stopping expansion bills. Legislatures are starting to question the risks to patients, but academics and practitioners have to take an active interest in getting the message to legislators. Otherwise we don't have a chance."

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EXHIBIT C –ADVANCED PRACTICE NURSING FOCUSES ON WELLNESS, PRIMARY CARE AND THE MEDICALLY UNDERSERVED

ANA NursingWorld
Official Web site of the American Nurses Association
Caring for Those Who Care

NursingFacts

Advanced Practice Nursing: A New Age in Health Care

Innovative advances in health care make frequent headlines, but there is an equally innovative, if somewhat misunderstood, treatment for the cost and accessibility woes plaguing the United States health care system. Almost 140,000 advanced practice nurses -- and their numbers are growing -- are carving out a new role in delivering timely, cost-effective, quality health care, especially to chronically underserved populations such as the elderly, the poor, and those in rural areas.
Some **60% to 80%** of primary and preventive care traditionally done by doctors can be done by a nurse for less money. This is not to say nurses work cheaper, but their cost-effectiveness reflects a variety of factors related to the employment setting, liability insurance, and the cost of education.
With an emphasis on health promotion and disease prevention and a proven record of providing excellent primary care in diverse settings, advanced practice nurses form a critical link in the solution to America's health care crisis. **Removing the barriers to advanced practice nursing would pay a healthy dividend now and in the future.**

WHO ARE THESE NURSES?

The advanced practice nurse (APN) is an umbrella term given to a registered nurse (RN) who has met advanced educational and clinical practice requirements beyond the 2 4 years of basic nursing education required of all RNs. Under this umbrella fall four principal types of APNs.

Nurse Practitioner (NP)

- Number: 48,237.
- Education: Most of the approximately 150 NP education programs in the United States today confer a master's degree. At least 36 states require NPs to be nationally certified by the ANA or a specialty nursing organization. By 1992, about 58% of NPs were certified by national organizations.
- What they do: Working in clinics, nursing homes, hospitals, or their own offices, NPs are qualified to handle a wide range of basic health problems. Most have a specialty -- for example, adult, family, or pediatric health care. NPs conduct physical exams, take medical histories, diagnose and treat common acute minor illnesses or injuries, order and interpret lab tests and X-rays, and counsel and educate clients. In 48 states, they may prescribe medication according to state law. Some work as independent practitioners and can be reimbursed by Medicare or Medicaid for services rendered. Others work for hospitals, health maintenance organizations (HMOs), or private industry.
- Average salary in 1992 was $43,636.

Certified Nurse Midwife (CNM)

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- Number: 7,400.
- Education: An average one and one-half years of specialized education beyond nursing school, either in an accredited certificate program, or like NPs, increasingly at the master's level.
- What they do: CNMs provide well-woman gynecological and low-risk obstetrical care including prenatal, labor and delivery, and post-partum care. In 1990, CNMs delivered 148,728 babies, or about 3.6 percent of all U.S. births that year, in hospitals, birth centers, and homes. An ANA meta-analysis of CNM care found that nurse-midwives performed fewer fetal monitors, episiotomies, and forceps deliveries, administered fewer IVs, delivered fewer low birthweight and premature infants, and had shorter patient hospital stays. CNMs have prescriptive authority in more than 33 states.
- Average salary in 1992 was $43,636.

Clinical Nurse Specialist (CNS)

- Number: 58,185.
- Education: Registered nurses with advanced nursing degrees -- master's or doctoral -- who are experts in a specialized area of clinical practice such as mental health, gerontology, cardiac or cancer care, and community or neonatal health.
- What they do: CNSs work in hospitals, clinics, nursing homes, their own offices, and other community-based settings, such as industry, home care and HMOs. Qualified to handle a wide range of physical and mental health problems, CNSs provide primary care and psychotherapy. They conduct health assessments, make diagnoses, deliver treatment, and develop quality control methods. Besides delivering direct patient care, CNSs work in consultation, research, education, and administration. Some work independently or in private practice and can be reimbursed by Medicare, Medicaid, Champus, and private insurers.
- Average salary in 1992 was $41,226.

Certified Registered Nurse Anesthetist (CRNA)

- Number: 25,238.
- Education: Registered nurses who complete 2-3 years higher education beyond the required four-year bachelor's degree, as well as meeting national certification and recertification requirements.
- What they do: In this oldest of the advanced nursing specialties, CRNAs administer more than 65 percent of all anesthetics given to patients each year, and are the sole providers of anesthetics in 85 percent of rural hospitals. Working sometimes with an MD anesthesiologist, but frequently independently, these nurse specialists work in almost every setting in which anesthesia is given operating rooms, dentist's offices, ambulatory surgical settings.
- Average salary in 1992 was $76,053.

ADVANCED PRACTICE NURSES ARE ACCESSIBLE. . .

They provide pre-employment physicals for employers, home health care to the elderly, health education in hospitals, schools, and community clinics, geriatric care in nursing homes, infectious disease control in prisons, pre- and post-natal care in inner-city and rural clinics, and psychotherapy in public and private practices.

ADVANCED PRACTICE NURSES ARE COST-EFFECTIVE . . .

Advanced practice nurses aren't low-priced doctor substitutes. They are first and foremost registered nurses, a profession with its own educational and licensing requirements, regulatory oversight by boards of nursing in all 50 states, and competency standards and continuing education requirements. APNs are skilled in performing a wide range of initial, or primary, health services, especially screening and preventive services, that if ignored, can lead to far more serious and costly health problems down the line.

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ADVANCED PRACTICE NURSES DELIVER QUALITY HEALTH CARE. . .

All advanced practice nurses must meet rigorous education, certification, and continuing education requirements. Standards of practice are set and monitored by nursing professional organizations. Advanced practice nurses work collaboratively with physicians and other health professionals to coordinate health services for the best outcome for the patient.

NUMEROUS STUDIES ATTEST TO THE VALUE OF APNS. . .

The Office of Technology Assessment, in a widely cited 1986 report, said NPs are "especially valuable in improving access to primary care and supplementary care in rural areas and in health programs for the poor, minorities and people without health insurance." OTA found the quality of NP care to be "as good as or better than care provided by physicians," and found NPs had "better communication, counseling and interviewing skills than physicians have." The National Research Council of the National Academy of Sciences found no significant difference in the outcome of care provided by CRNAs and physician-anesthesiologists. A nationwide survey conducted by the Gallup Organization found that 86 percent of the public is willing to accept APNs as everyday health care providers.

IF ADVANCED PRACTICE NURSES ARE SO ACCESSIBLE AND AFFORDABLE, WHY DON'T WE USE THEM TO HELP PROVIDE CARE TO OVER 60 MILLION UNINSURED AND UNDERINSURED CITIZENS?

A study published in the Yale Journal on Regulation by Barbara J. Safriet, associate dean of the Yale Law School, addressed that question. "Unnecessary restrictions on their scope of practice, prescriptive authority, and eligibility for reimbursement actively impairs these providers' proven ability to safely meet the health care needs of many of our neediest citizens," Safriet said. "Removing these barriers would be an important first step to restoring the focus on health, and on care, that our system so desperately needs."

ADVANCED PRACTICE NURSES. . . A PRIMARY PART OF U.S. HEALTH CARE

The U.S. health care system is largely based on a "medical model" of care that relies on physicians to be the "gatekeepers" to services. As medical specialization has grown, there has been a parallel growth in sophisticated medical technology and treatment to the exclusion of needed basic primary health care services.
Advanced practice nurses are capable of providing much of that needed basic care. Most preventive and primary health care does not require the expensive specialization that characterizes physician education today. America's nurses believe that:

- the health care system must be restructured to focus on prevention and primary care rather than high-tech treatment and cure of disease.
- regulatory and legislative barriers to increased use of nurses as health care providers must be removed.
- basic health care services must be available to all citizens in convenient, community locations.

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EXHIBIT D – CONSUMERS DEMAND COMPLEMENTARY AND ALTERNATIVE MEDICINE

Advance Data
From Vital and Health Statistics
Number 343 • May 27, 2004

Complementary and Alternative Medicine Use Among Adults: United States, 2002

Patricia M. Barnes, M.A., and Eve Powell-Griner, Ph.D., Division of Health Interview Statistics; and Kim McFann, Ph.D., and Richard L. Nahin, Ph.D., M.P.H., National Center for Complementary and Alternative Medicine, National Institutes of Health

Abstract

Objective—This report presents selected estimates of complementary and alternative medicine (CAM) use among U.S. adults, using data from the 2002 National Health Interview Survey (NHIS), conducted by the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS).

Methods—Data for the U.S. civilian noninstitutionalized population were collected using computer-assisted personal interviews (CAPI). This report is based on 31,044 interviews of adults age 18 years and over. Statistics shown in this report were age adjusted to the year 2000 U.S. standard population.

Results—Sixty-two percent of adults used some form of CAM therapy during the past 12 months when the definition of CAM therapy included prayer specifically for health reasons. When prayer specifically for health reasons was excluded from the definition, 36% of adults used some form of CAM therapy during the past 12 months. The 10 most commonly used CAM therapies during the past 12 months were use of prayer specifically for one's own health (43.0%), prayer by others for one's own health (24.4%), natural products (18.9%), deep breathing exercises (11.6%), participation in prayer group for one's own health (9.6%), meditation (7.6%), chiropractic care (7.5%), yoga (5.1%), massage (5.0%), and diet-based therapies (3.5%). Use of CAM varies by sex, race, geographic region, health insurance status, use of cigarettes or alcohol, and hospitalization. CAM was most often used to treat back pain or back problems, head or chest colds, neck pain or neck problems, joint pain or stiffness, and anxiety or depression. Adults age 18 years or over who used CAM were more likely to do so because they believed that CAM combined with conventional medical treatments would help (54.9%) and/or they thought it would be interesting to try (50.1%). Most adults who have ever used CAM have used it within the past 12 months, although there is variation by CAM therapy.

Keywords: complementary and alternative medicine • National Health Interview Survey

Introduction

Complementary and alternative medicine (CAM) is a group of diverse medical and health care systems, therapies, and products that are not presently considered to be part of conventional medicine. The U.S. public's use of CAM increased substantially during the 1990s (1–11). This high rate of use translates into large out-of-pocket expenditures on CAM. It has been estimated that the U.S. public spent between $36 billion and $47 billion on CAM therapies in 1997 (5). Of this amount, between $12.2 billion and $19.6 billion was paid out-of-pocket for the services of professional CAM health care providers such as chiropractors, acupuncturists, and massage therapists. These fees are more than the U.S. public paid out-of-pocket for all hospitalizations in 1997 and about half that paid for all out-of-pocket physician services (12).

Explanations for this growth in CAM use have been proposed, including marketing forces, availability of information on the Internet, the desire of patients to be actively involved with medical decision making, and dissatisfaction with conventional

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for Health Statistics

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EXHIBIT E- OBJECTIVE MEASUREMENT IS ESSENTIAL TO ELIMINATING HEALTH DISPARITIES

The excerpts below are derived from a report by The Henry Kaiser Family Foundation.[326] These indicate the need for attention to racial/ethnic disparities in medical care.

INTRODUCTION

The issue of racial/ethnic disparities in medical care has received a great deal of attention since the Henry J. Kaiser Family Foundation released the first edition of *Key Facts: Race, Ethnicity, and Medical Care* in 1999. Although there had been questions about whether a problem existed, some level of consensus has emerged, due in part to the release of the Institute of Medicine (IOM) report *Unequal Treatment* in 2001. After an exhaustive review of published research, the IOM concluded that racial/ethnic minority Americans "tend to receive a lower quality of health care than non-minorities, even when access-related factors, such as patients' insurance status and income, are controlled."

Documented racial/ethnic disparities in health and healthcare have resulted in public and private sector responses at the national, state, and local levels. For example, the field has seen public sector efforts such as the establishment of a National Center on Minority Health and Health Disparities at the National Institutes of Health (NIH), and private sector efforts such as Aetna's new initiative to gather racial/ethnic background data from its members in order to develop prevention, education, and treatment programs to address disparities in care. The Kaiser Family Foundation and The Robert Wood Johnson Foundation have also partnered with 13 national medical, public health and business organizations to raise physician awareness of disparities in care and to engage doctors in dialogue about how to eliminate them.

This update of *Key Facts: Race, Ethnicity, and Medical Care,* like the first, is intended to serve as a quick reference source on the health, health insurance coverage, healthcare access and quality among racial/ethnic minority groups in the United States. The document highlights the best available data and research, providing a selective review of the literature. *Key Facts* is divided into five sections, beginning with an overview of the demographic characteristics of the U.S. population. Section 2 presents health measures, stratified when possible by a measure of socioeconomic status. Section 3 profiles patterns of health insurance coverage. Sections 4 and 5 present findings on access to and use of primary and specialty medical care. Whenever possible, these findings are adjusted for social and clinical factors.

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CONCLUSION

Key Facts: Race, Ethnicity, and Medical Care presents compelling evidence of racial and ethnic differences in health insurance coverage, access to primary care, and treatment for specific medical conditions. In some studies, these differences are reduced, if not eliminated, when comparing minority populations and whites of similar socio-economic conditions, insurance coverage, and health status. Even when differences persist, it should be noted that differentials in care may not be inherently problematic, and that the level of care obtained by whites is not necessarily the appropriate standard for comparison.

Efforts to address racial/ethnic differences in health care require data systems and analyses to assess problems and progress. Further research is needed to better understand and assess the extent to which these differentials reflect barriers to needed care and compromise health outcomes. While it is known that financial incentives and barriers affect patterns of health care use, less is known about how other factors, such as patient preferences or site of care affect patterns of care. The challenge facing health policy researchers and health providers is to identify and disentangle the many complex factors that account for these differentials, so that the sources of healthcare inequity can be addressed.

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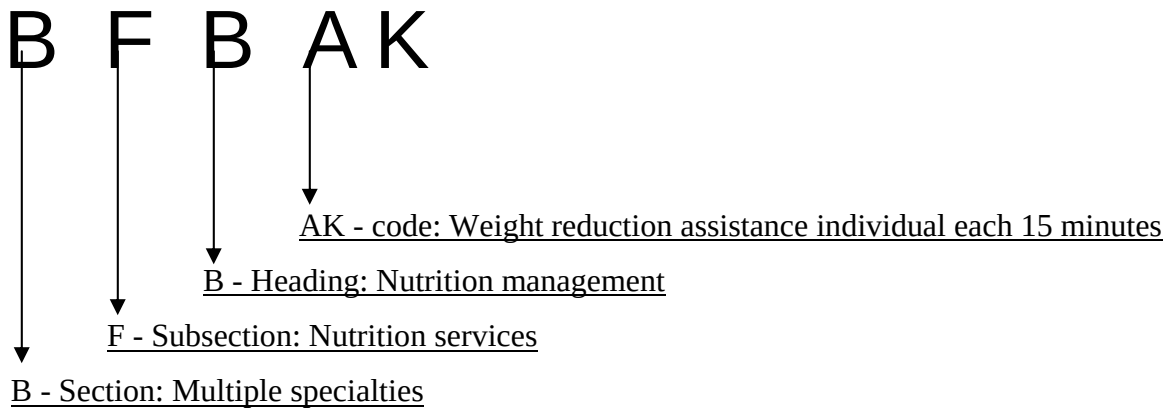
EXHIBIT F – THE DESIGN OF ABC CODES SUPPORTS RESEARCH, MANAGEMENT AND COMMERCE

ABC Codes Are Hierarchic.

The following description illustrates the coding hierarchy of ABC code **BFBAK** is for "Weight reduction assistance individual each 15 minutes, Nutrition management, Nutrition services, Multiple specialties."

The expanded definition is "Assisting a client in losing weight and/or decreasing his or her body fat. Service is billed in 15-minute increments."


B F B AK
AK - code: Weight reduction assistance individual each 15 minutes
B - Heading: Nutrition management
F - Subsection: Nutrition services
B - Section: Multiple specialties

The meaning of the first three letters of each ABC code is shown in the following code tree.

(This code tree represents the latest definitions. A new version will be released prior to this year's end.)

The ABC Code Tree is Intuitive.

A - Clinical practice management
- A - Client evaluation
  - *A - New client in-office with ICD diagnosis*
  - *B - Existing client in-office with ICD diagnosis*
  - *C - New client home-visit with ICD diagnosis*
  - *D - Existing client home-visit with ICD diagnosis*
  - *E - New client in-facility with ICD diagnosis*
  - *F - Existing client in-facility with ICD diagnosis*
- B - Client health maintenance
  - *A - New client wellness visit with or without ICD diagnosis*
  - *B - Existing client wellness visit with or without ICD diagnosis*

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C - Client assessment
- *A - New client in-office without ICD diagnosis*
- *B - Existing client in-office without ICD diagnosis*
- *C - Remote location new client without ICD diagnosis*
- *D - Remote location existing client without ICD diagnosis*
- *E - New client in-office with nursing diagnosis*
- *F - Existing client in-office with nursing diagnosis*
- *G - New client home-visit with nursing diagnosis*
- *H - Existing client home-visit with nursing diagnosis*
- *I - New patient in-facility with nursing diagnosis*
- *J - Existing patient in-facility with nursing diagnosis*

D - General service and referral codes
- *A - Consultations between practitioners with or without ICD diagnosis*
- *B - Extended services with or without ICD diagnosis*
- *C - Phone conversations with or without ICD diagnosis*
- *D - Analysis and/or documentation services with or without ICD diagnosis*
- *X - Recommendation and/or prescription services with or without ICD diagnosis*
- *Y - Adjunct care orders and/or referrals with or without ICD diagnosis*
- *Z - Preparing and/or dispensing and/or training services with or without ICD diagnosis*

H - Reference mapping
- *A - Tracking code use with or without ICD diagnosis*

B - Multiple specialties

A - Physical modalities
- *A - Cold*
- *B - Electrical or magnetic*
- *C - Heat*
- *D - Water*
- *E - Light*
- *F - Mechanical*
- *G - Sound*

B - Movement modalities
- *A - Activity or exercise*
- *B - Joint mobilization*
- *C - Traction*
- *E - Aquatic activity*

C - Rehabilitation and training modalities
- *A - Rehabilitative treatments and/or training*
- *B - Work conditioning*
- *C - Ergonomics*
- *D - Taping services*

D - Physical test and/or measurement modalities
- *A - Miscellaneous tests and/or measurements*
- *B - Body composition testing*
- *C - Electronic muscle testing*
- *D - Manual muscle testing*
- *E - Physical performance testing*
- *F - Range-of-motion tests and/or measurements*

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E - Allergy services
B - Allergy treatments
F - Nutrition services
A - Nutrition education
B - Nutrition management

C - Practice specialties
A - Oriental medicine services
B - General Oriental procedures
C - Oriental modalities
D - Oriental therapies
E - Oriental anesthesia
B - Somatic and/or massage practices
A - Body-mind
B - Bodywork
C - Energy work
E - Massage
G - Oriental massage
H - Somatic education
C - Chiropractic services
A - Spinal adjustments
B - Nonspinal adjustments
C - Miscellaneous chiropractic services
D - Mental health services
A - Mental health counseling
B - Mental health testing and/or interpretation
C - Hypnotherapy and/or meditation
D - Psychotherapy
E - Midwifery services
A - Miscellaneous midwifery
B - Prenatal
C - Labor and delivery
D - Postpartum
E - Newborn
F - Naturopathic services
A - Osseous manipulations
B - Visceral manipulations
C - Miscellaneous naturopathy
G - Osteopathic services
A - Miscellaneous osteopathy
H - Indigenous healing practices
A - Ayurvedic medicine
B - Native American healing
C - Curandera
D - Shamanism
I - Spiritual care services
A - Christian Science care
B - Spiritual nursing care
C - Multidenominational care
J - Other specialty services
A - Naprapathic manipulations

D - Laboratory and/or office procedures
A - Heart and vascular services

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F - Miscellaneous heart or vascular services

B - Neurological services
B - Nerve conduction

D - Substance administration services
A - Miscellaneous substance administration
B - Injections
C - Substance administration management

E - Laboratory services
A - General blood analysis
B - Mineral analysis
C - Nutritional analysis
D - Metabolic analysis
E - Blood vitamin analysis
F - Saliva analysis
G - Stool analysis
I - Urinalysis
J - General laboratory tests
L - Chemical screening
M - Male-specific tests
O - Female-specific tests
P - Allergy tests
Z - Specimen collection

F - Radiology services
A - Computer-enhanced radiology

H - Miscellaneous laboratory and/or office procedures and services
A - Spectroscopy
C - Thermography

E - Physical resources

A - Materials and/or supplies
A - Miscellaneous materials and/or supplies

B - Applicants
A - Miscellaneous applicants

C - Solutions
A - Allergen solutions
B - Miscellaneous solutions

G - Herbs and natural substances

A - Oriental herbs and natural substances
A to Z - Oriental herbs and natural substances letter A - Z

B - Western herbs and natural substances
A to Z - Western herbs and natural substances letter A - Z

C - Miscellaneous substances
A - Flower essences
B - Nutraceuticals
C - Essential oils

H - Remedies

A - Homeopathic remedies
A to Z - Homeopathic remedies letter A - Z

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N - Nursing

A - Nursing interventions

A - Common nursing interventions

B - Common nursing interventions II

C - Family planning and/or genetic counseling

B - Nursing-facilitated education

A - Patient education and/or counseling

B - Public health

C - Speech therapy

D - Family planning

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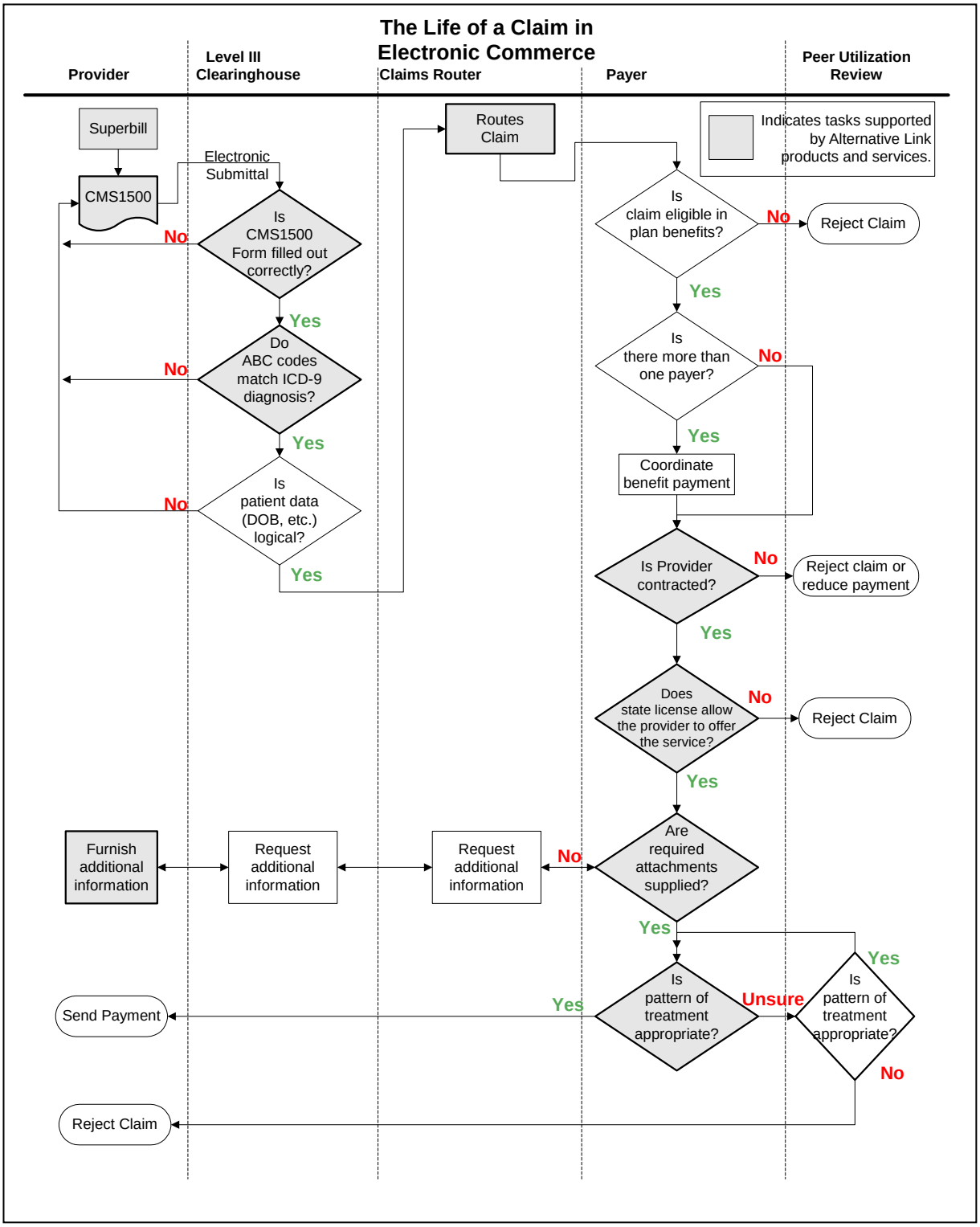
ABC Codes Extend the Benefits of EDI to Integrative Healthcare Claims.



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ABC Codes Help Identify Sources of Medical Cost Savings.

Alternative Link continues to build and validate medical cost-savings models with demonstration sites such as MediMerge, Bridges in Medicine, NaviMedix and others.

The following tables illustrate the direction of medical cost-savings research efforts.

Table 102. Demonstration sites continue to compile data to refine and validate medical cost-savings models.

Table No.	Table Name	Column Headings
1.	High Cost Diagnoses	High Cost ICD-9s • Diagnostic Descriptions • Annual Cost of Care • Total Cost of Care
2.	High Cost Diagnosis-Related Groups (DRGs)	High Cost DRGs • Corresponding ICD-9s • Diagnostic Descriptions • Allowable/Payment • Annual Episodes
3.	Top CPT Codes Associated With High Cost Diagnoses	Top CPTs Associated With High Cost ICD-9s in Claim Forms • Annual Volume • RVU/RBRVS Score • Allowable/Payment
4.	CAM Approaches to High Cost Diagnoses	Potential ABCs Associated With High Cost ICD-9 in Claim Forms • Annual Volume • RVU/RBRVS Score • Allowable/Payment
5.	CAM Approaches to High Cost DRGs	Potential ABCs Associated With High Cost DRGs in Claim Forms • Annual Volume • RVU/RBRVS Score • Allowable/Payment
6.	High Cost CPT Codes Independent of Diagnosis	High Cost CPTs • Service Descriptions • Annual Volume • Allowable/Payment • RVU/RBRVS Score
7.	Top Diagnoses Associated with High Cost CPT Codes	For Each High Cost CPT: Top ICD-9s Associated With CPT in Claim Forms • Annual Volume
8.	Top CAM-Responsive Diagnoses	CAM-Responsive ICD-9s • Diagnostic Descriptions • Annual Cost of Care • Total Cost of Care
9.	Top CPT Codes Associated with CAM-Responsive Diagnoses	For Each CAM-Responsive ICD-9: Top CPTs Associated With ICD-9 in Claim Forms • Annual Volume • RVU/RBRVS Score • Allowable/Payment
10.	ABC Codes Relevant to Top CAM-Responsive Diagnoses	Potential ABCs Associated With CAM-Responsive ICD-9s in Claim Forms • Annual Volume • RVU/RBRVS Score • Allowable/Payment
11.	Top Nursing-Responsive Diagnoses	Nursing-Responsive ICD-9s • Diagnostic Descriptions • Annual Cost of Care • Total Cost of Care
12.	Top CPT Codes Associated with Nursing-Responsive Diagnoses	Top CPTs Associated With Nursing-Responsive ICD-9s in Claim Forms • Annual Volume • RVU/RBRVS Score • Allowable/Payment
13.	ABC Codes Relevant to Top Nursing-Responsive Diagnoses	Potential ABCs Associated With Top Nursing-Responsive ICD-9s in Claim Forms • Annual Volume • RVU/RBRVS Score• Allowable/Payment

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EXHIBIT G – A COMPANION DOCUMENT SUPPORTS THE USE OF ABC CODES IN TRANSACTIONS MANDATED UNDER HIPAA

Introduction

This companion document provides guidance for using ABC codes for business transactions mandated within the Health Insurance Portability and Accountability Act (HIPAA). It can be used by entities that have registered to use ABC codes and their contractual trading partners as authorized by the Secretary of Health and Human Services on January 16, 2003. This companion document for ABC codes may also be used by entities for which the named transactions are not mandated by HIPAA rules.

Users should follow the implementation instructions in the X12N implementation guides named as HIPAA standards under the Transactions and Code Sets Rule, with the modifications stated below for each transaction. These modifications are consistent with the guides published originally under the August 17, 2000 Final Rule in the Federal Register, as well as the addenda to the implementation guides published in the Final Modifications Rule on February 20, 2003, as corrected in the Federal Register on March 10, 2003.

There are specific instructions for each HIPAA implementation guide in which ABC codes might be used. Guidance is provided for

- identifying where and under which circumstances ABC codes are used in the transaction;
- identifying allied and public health, nursing, CAM and/or integrative healthcare services when they are to be identified in the guide in other locations; and
- identifying a transaction that is created in conformance with this companion document and its relationship to the HIPAA implementation guides governed by the final rules.

Addenda Version Required

As of October 16, 2003, HIPAA rules require use of the guides named in the Final Rule for Transactions and Code Sets as modified in the Addenda documents named in the Rule modifying the transactions. Therefore, trading partners implementing this companion document should exchange transactions based on the addenda version.

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837 Health Care Claim: Professional

Transaction Identification

To identify the transaction as compliant with this companion document use the following identifiers in GS08 and the REF Transmission Type Identification segment in the Header:

Identification of the Addenda version: 004010X098AB

Identification of ABC Codes

To identify ABC codes as the procedure codes in the service line information in Loop 2400, in data element SV101-1 use code:

ZR Service Control Identification.

This code is used to identify the ABC codes. (See information for the code source on the final page of this document.)

Users should note that when the X12 version 4050 guides are released and are adopted under HIPAA, the code adopted in later versions of the X12 standard that specifically identifies the ABC codes is **WK** and that code will appear as a code choice in the implementation guide.

In the implementation guides, data elements SV101-3, SV101-4, SV101-5, and SV101-6 are used for any modifiers to the procedure code from the code list as identified in *SV101-1*. The modifiers in the ABC coding manual are compatible with the data format as it exists, and therefore no changes are needed to enter ABC code modifiers when using the ABC codes in this transaction.

837 Health Care Claim: Institutional

Transaction Identification
To identify the transaction as compliant with this companion document use the following identifiers in GS08 and the REF Transmission Type Identification segment in the Header:

Identification of the Addenda version: 004010X096AB

Identification of ABC Codes

To identify ABC codes as the procedure codes in the service line information in Loop 2400, in data element SV202-1 use code:

ZR Service Control Identification

This code is used to identify the ABC codes. (See information for the code source on the final page of this document.)

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Users should note that when the X12 version 4050 guides are released and are adopted under HIPAA, the code adopted in later versions of the X12 standard that specifically identifies the ABC codes is **WK** and that code will appear as a code choice in the implementation guide.

In the implementation guide, data elements SV202-3, SV202-4, SV202-5, and SV202-6 are used for any modifiers to the procedure code as identified in SV202-1. The modifiers in the ABC Code manual are compatible with the data format as it exists, and therefore no changes are needed to enter ABC code modifiers when using the ABC codes in this transaction.

When using an NUBC revenue code to identify allied and public health, nursing, CAM and/or integrative healthcare services in SV201, use the code stated in the NUBC manual, revenue code 2100 or a more specific code in the 210X range as specified.

Should it be necessary to identify a principal or other procedure in the HI segments for Principal Procedure Information or Other Procedure Information, use code ABS (Assigned by Sender) in HI01-1for the principal procedure to mean ABC codes. In the unlikely event that it is necessary to send an ABC code for inpatient procedures for both Principal and Other Procedures, for Other Procedure Information, in HI01-1, HI02-1, HI03-1, HI04-1,HI04-1,HI06-1,HI07-1,HI08-1,HI09-1,HI10-1,HI11-1,HI12-1 use code:

ABR (Assigned by Receiver)

This code is used to identify the ABC codes. (See information for the code source on the last page of this document.)

If an ABC code is required in the HI segment for Other Procedure Information but not in the HI segment for Principal Procedure Information, use:

ABS (Assigned by Sender)

This code is used to identify the ABC codes. (See information for the code source on the last page of this document.)

Users should note that when the X12 version 4050 guides are released and are adopted under HIPAA, the code adopted in later versions of the X12 standard that specifically identifies the ABC codes in the SV2 segment is **WK** and in the HI segment is **CAH**. Those codes will appear as code choices in the implementation guide.

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835 Health Care Claim Payment/Advice

Transaction Identification
To identify the transaction as compliant with this companion document use the following identifiers in GS08:

Identification of the Addenda version: 004010X091AB

Identification of ABC Codes

In SVC01-1 and SVC06-1 data elements within Loop 2110 for an identifier code use:

ZR Service Control Identification

This code is used to identify the ABC codes. (See information for the code source on the last page of this document.)

Users should note that when the X12 version 4050 guides are released and are adopted under HIPAA, the code adopted in later versions of the X12 standard that specifically identifies the ABC codes is **WK** and that code will appear as a code choice in the implementation guide.

In the implementation guide, data elements SVC01-3, SVC01-4, SVC01-5, SVC01-6 and elements SVC06-3, SVC06-4, SVC06-5, and SVC06-6 are used for any modifiers to the procedure code from the code list as identified in SVC01-1 or SVC06-1. The ABC code modifiers, found in the ABC coding manual, are compatible with the data format as it exists, and therefore no changes are needed to enter ABC code modifiers when using the ABC codes in this transaction.

When using an NUBC revenue code to identify allied and public health, nursing, CAM and/or integrative healthcare services in SVC01-2 or SVC04, use the code stated in the NUBC manual, revenue code 2100 or a more specific code in the 210X range as specified.

270/271 Health Care Eligibility Benefit Inquiry and Response

Transaction Identification
To identify the transaction as compliant with this companion document use the following identifiers in GS08:

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Identification of the Addenda version: 004010X092AB

Identification of ABC Codes

270 Inquiry

In a 270 Inquiry transaction, to identify the services for which eligibility is requested, use the following guidance. In the EQ segment in Subscriber Loop 2110C or Dependent Loop 2110D, do not use EQ01, but use EQ02. In EQ02-1, use code:

ZR Service Control Identification

This code is used to identify the ABC codes. (See information for the code source on the last page of this document.)

Users should note that when the X12 version 4050 guides are released and are adopted under HIPAA, the code adopted in later versions of the X12 standard that specifically identifies the ABC codes is **WK** and that code will appear as a code choice in the implementation guide.

In the implementation guide, data elements EQ02-3, EQ02-4, EQ02-5, and EQ02-6 are used for any modifiers to the procedure code from the code list as identified in EQ02-1. The ABC code modifiers, found in the ABC coding manual, are compatible with the data format as it exists, and therefore no changes are needed to enter ABC code modifiers when using the ABC codes in this transaction.

If payer does not support procedure code level of detail on eligibility requests, treat an inquiry with EQ02 as a generic inquiry (as if EQ01 appeared with the code value 30 in EQ01).

271 Response

In a 271 response transaction, to identify services for which eligibility is reported, use the following guidance. In the EB segment in Subscriber Loop 2110C or Dependent Loop 2110D, do not use EB03 to identify specific allied and public health, nursing, CAM and/or integrative healthcare coverage, but use EB13, with the value in EB13-1:

ZR Service Control Identification

This code is used to identify the ABC codes. (See information for the code source on the last page of this document.)

Users should note that when the X12 version 4050 guides are released and are adopted under HIPAA, the code adopted in later versions of the X12 standard that specifically identifies the ABC codes is **WK** and that code will appear as a code choice in the implementation guide.

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If a payer does not support procedure code level of detail on eligibility requests, reply with the generic response as indicated in the implementation guide. That response is a value in EB03 of 30, and EB13 is not sent.

In the implementation guide, data elements EB13-3, EB13-4, EB13-5, and EB13-6 are used for any modifiers to the procedure code from the codes list as identified in EB13-1. The ABC code modifiers, found in the ABC coding manual, are compatible with the data format as it exists, and therefore no changes are needed to enter ABC code modifiers when using the ABC codes in this transaction.

276/277 Health Care Claim Status Request and Response

Transaction Identification
To identify the transaction as compliant with this companion document use the following identifiers in GS08:

Identification of the Addenda version: 004010X093AB

Identification of ABC Codes

In SVC01-1 data element within the 276 Loop 2210D (Subscriber) and Loop 2210E (Dependent), as well as 277 Loop 2220D (Subscriber) and Loop 2220E (Dependent) for an identifier code use:

ZR Service Control Identification

This code is used to identify the ABC codes. (See information for the code source on the last page of this document.)

Users should note that when the X12 version 4050 guides are released and are adopted under HIPAA, the code adopted in later versions of the X12 standard that specifically identifies the ABC codes is **WK** and that code will appear as a code choice in the implementation guide.

In the implementation guide, data elements SVC01-3, SVC01-4, SVC01-5, and SVC01-6 are used for any modifiers to the procedure code from the code list as identified in SVC01-1. The ABC code modifiers, found in the ABC coding manual, are compatible with the data format as it exists, and therefore no changes are needed to enter ABC code modifiers when using the ABC codes in this transaction.

When using an NUBC revenue code to identify allied and public health, nursing, CAM and/or integrative healthcare services in SVC01-2 or SVC04 use the code stated in the NUBC manual, revenue code 2100 or a more specific code in the 210X range as specified.

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278 Health Care Services Review – Request for Review and Response

Transaction Identification
To identify the transaction as compliant with this companion document use the following identifiers in GS08:

Identification of the Addenda version: 004010X094AB

Identification of ABC Codes

In Loop 2000F in both the Request and Response transactions, use UM03 in the UM Health Care Service Review Information segment only if an applicable code exists. Always use the HI Procedure Code segment. The value in HI01-1, HI02-1, HI03-1, HI04-1, HI04-1, HI06-1, HI07-1, HI08-1, HI09-1, HI10-1, HI11-1, and HI12-1 will be the code:

ABS (Assigned by Sender)

This code is used to identify the ABC codes. (See information for the code source later in this document.)

Users should note that when the X12 version 4050 guides are released and are adopted under HIPAA, the code adopted in later versions of the X12 standard that specifically identifies the ABC codes in the SV2 segment is **WK** and in the HI segment is **CAH**. Those codes will appear as code choices in the implementation guide.

834 Benefit Enrollment and Maintenance

Transaction Identification
To identify the transaction as compliant with this companion document use the following identifiers in GS08:

Identification of the Addenda version: 004010X095AB

Identification of Allied and Public Health, Nursing, CAM and Other Integrative Healthcare Coverages

In the HD Health Coverage segment in Loop 2300, use PRA (Practitioners) in HD03, and use HD04 to put in a description of the allied and public health, nursing, CAM and/or integrative healthcare coverage in the health plan, as provided in plan documents. If multiple modalities are covered, repeat loop 2300 for each type of coverage that must be identified.

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ABC Code Availability

ABC Codes are published in *The ABC Coding Manual for Integrative Healthcare* available from:
Alternative Link
6121 Indian School Rd NE
Suite 131
Albuquerque, NM 87110
505-875-0001

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EXHIBIT H – 45 CFR 162.940 SUPPORTS COMMERCIALIZATION AND TESTING OF PROPOSED MODIFICATIONS TO THE HIPAA STANDARDS

[Code of Federal Regulations]
[Title 45, Volume 1]
[Revised as of October 1, 2002]
From the U.S. Government Printing Office via GPO Access
[CITE: 45CFR162.940]

[Page 680-681]

TITLE 45--PUBLIC WELFARE

AND HUMAN SERVICES

PART 162--ADMINISTRATIVE REQUIREMENTS--Table of Contents

Subpart I--General Provisions for Transactions

§162.940 Exceptions from standards to permit testing of proposed modifications.

(a) Requests for an exception. An organization may request an exception from the use of a standard from the Secretary to test a proposed modification to that standard. For each proposed modification, the organization must meet the following requirements:

(1) Comparison to a current standard. Provide a detailed explanation, no more than 10 pages in length, of how the proposed modification would be a significant improvement to the current standard in terms of the following principles:

(i) Improve the efficiency and effectiveness of the health care system by leading to cost reductions for, or improvements in benefits from, electronic health care transactions.

(ii) Meet the needs of the health data standards user community, particularly health care providers, health plans, and health care clearinghouses.

(iii) Be uniform and consistent with the other standards adopted under this part and, as appropriate, with other private and public sector health data standards.

(iv) Have low additional development and implementation costs relative to the benefits of using the standard.

(v) Be supported by an ANSI-accredited SSO or other private or public organization that would maintain the standard over time.

(vi) Have timely development, testing, implementation, and updating procedures to achieve administrative simplification benefits faster.

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(vii) Be technologically independent of the computer platforms and transmission protocols used in electronic health transactions, unless they are explicitly part of the standard.

(viii) Be precise, unambiguous, and as simple as possible.

(ix) Result in minimum data collection and paperwork burdens on users.

(x) Incorporate flexibility to adapt more easily to changes in the health care infrastructure (such as new services, organizations, and provider types) and information technology.

(2) Specifications for the proposed modification. Provide specifications for the proposed modification, including any additional system requirements.

(3) Testing of the proposed modification. Provide an explanation, no more than 5 pages in length, of how the organization intends to test the standard, including the number and types of health plans and health care providers expected to be involved in the test, geographical areas, and beginning and ending dates of the test.

(4) Trading partner concurrences. Provide written concurrences from trading partners who would agree to participate in the test.

(b) Basis for granting an exception. The Secretary may grant an initial exception, for a period not to exceed 3 years, based on, but not limited to, the following criteria:

(1) An assessment of whether the proposed modification demonstrates a significant improvement to the current standard.

(2) The extent and length of time of the exception.

(3) Consultations with DSMOs.

(c) Secretary's decision on exception. The Secretary makes a decision and notifies the organization requesting the exception whether the request is granted or denied.

(1) Exception granted. If the Secretary grants an exception, the notification includes the following information:

(i) The length of time for which the exception applies.

(ii) The trading partners and geographical areas the Secretary approves for testing.

(iii) Any other conditions for approving the exception.

(2) Exception denied. If the Secretary does not grant an exception, the notification explains the reasons the Secretary considers the proposed modification would not be a significant improvement to the current standard and any other rationale for the denial.

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(d) Organization's report on test results. Within 90 days after the test is completed, an organization that receives an exception must submit a report on the results of the test, including a cost-benefit analysis, to a location specified by the Secretary by notice in the **Federal Register**.

(e) Extension allowed. If the report submitted in accordance with paragraph (d) of this section recommends a modification to the standard, the Secretary, on request, may grant an extension to the period granted for the exception.

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EXHIBIT I – HHS AUTHORIZED THE COMMERCIAL USE AND COST-BENEFIT EVALUATION OF ABC CODES IN HIPAA TRANSACTIONS

THE SECRETARY OF HEALTH AND HUMAN SERVICES
Washington, D.C. 20201

JAN 16 2003

Ms. Synthia Molina
Chief Executive Officer
Alternative Link
P.O. Box 30168
Albuquerque, NM 87190

Dear Ms. Molina:

Thank you for your letter requesting an exception from the use of HIPAA code sets to test a proposed modification to those standards. Specifically, you propose to test the use of the ABC code set to describe the products and services delivered by Complementary and Alternative Medicine and nursing practitioners. Your application indicates that the current adopted standard code sets do not contain adequate or specific elements to describe a number of alternative therapies and procedures. Our understanding is that the ABC code set would be used in conjunction with HCPCS codes. I am pleased to approve this request, subject to the conditions set out below. Yours was the first request we received for an exception under section 45 CFR 162.940, and this process is critical in order for the HIPAA standards to improve and evolve over time. Please note that the conditions set out several additional pieces of information that you will need to supply prior to commencing the pilot. In addition, we have enclosed some guidance for your use in establishing an evaluation methodology.

Conditions of Approval

1. This approval covers the use of the ABC code set by HIPAA-covered entities (health care providers, health plans, and health care clearinghouses) to describe products and services in HIPAA transactions. Any use of the codes by noncovered entities or for purposes other than conducting HIPAA transactions is not governed by the HIPAA regulations.

2. The start date of the pilot will be determined by you after consultation with the pilot participants. You may begin at any time prior to October 16, 2003. The duration of the pilot will be 2 years from the start date. You must notify us of your proposed start date and of the actual start date within 30 days of that date.

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3. Participants must include health care providers and at least one health plan, and electronic transactions must also be included.

4. You must identify all pilot participants within 60 days of the date of this letter. Please provide a complete list including name, address, and tax identification number. This information is needed in the event that a complaint is submitted against a participant related to the participation in the pilot project. You may not add participants after submitting the list.

5. The pilot evaluation must be conducted in accordance with the criteria in 45 CFR 162.940. If the pilot participants include noncovered entities or the code set is used for other purposes than conducting HIPAA transactions, the evaluation must clearly differentiate the costs and benefits from those.

We look forward to seeing the results of this pilot. We encourage you to submit your evaluation methodology for our review prior to starting the pilot, and would be happy to meet with you to review it. You should submit the additional information requested to Jared Adair, Director, Office of HIPAA Standards at (410) 786-4160, and contact her if you have any further questions.

I also will provide this response to Ms. Melinna Giannini.

Sincerely,

Tommy G. Thompson

Enclosure

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Evaluating Results of the ABC Code Pilot

Below is a list of some of the specific criteria from section 162.940 with our recommendations for addressing them in the evaluation. The evaluation must separately quantify the costs and benefits of the use of ABC codes in HIPAA transactions between covered entities from any other costs and benefits.

162.940 (a) (1) (i) Improve the efficiency and effectiveness of the health care system by leading to cost reduction for, or improvements in benefits from, electronic health care transactions.
Your documentation states that because ABC codes are more precise their use reduces administrative burdens which in turn reduces costs, and that ABC codes allow stakeholders to manage access, quality, and cost of CAM and nursing care by using business processes identical to those used to manage conventional physician services. Please provide clarification from your testing on how costs would be reduced or benefits improved with 3 to 5 specific examples comparing ABC codes with other adopted standard codes.

162.940 (a) (1) (ii) Meet the needs of the health data standards user community, particularly health care providers, health plans, and health care clearinghouses.
Pilot participants should include providers, health plans, and if possible at least one clearinghouse. The evaluation should document the volume of transactions, and specifically the volume of electronic transactions conducted, which transactions were used, and any problems encountered.

162.940 (a) (1) (iv) Have low additional development and implementation costs relative to the benefits of using the standard.
The pilot participants should include covered entities that have not previously used the ABC codes, as well as entities that have already adopted them. The evaluation should study the implementation costs of these two groups separately.

162.94 (a) (1) (vi) Have timely development, testing, implementation, and updating procedures to achieve administrative simplification benefits faster.
Your documentation explains the development of a new term and corresponding code but does not provide details on the openness of ABC code maintenance. Please provide a description of how the update process worked throughout the pilot.

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162.940 (a) (1) (vii) Be technologically independent of the computer platforms and transmission protocols used in electronic health transactions, unless they are explicitly part of the standard.
The evaluation should demonstrate that ABC codes can work on different computer platforms.

162.940 (a) (1) (viii) Be Precise, unambiguous and as simple as possible
Provide sample instructions that participants used to train coders, as well as data regarding the time needed to train coders on ABC use, error rates, etc..

162.940 (a) (1) (ix) Result in minimum data collection and paperwork burdens on users.
The CAM and Nursing Coding Manual includes a number of undefined codes. Please provide an explanation of how the undefined codes are tracked and from 1-3 sample reports of ABC code use during your testing that demonstrate reduction in data collection and paperwork burdens.

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EXHIBIT J – CMS CONFIRMED TRADING PARTNERS OF REGISTRANTS COULD USE OF ABC CODES IN HIPAA TRANSACTIONS

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-15
Baltimore, Maryland 21244-1850

August 6, 2003

Ms. Melinna Giannini
President
Alternative Link
6121 Indian School Road NE
Suite 131
Albuquerque NM 87110

Dear Ms. Giannini:

Ms. Leslie Norwalk has asked me to respond to your email requesting clarification on the ability of contractual trading partners of registered participants in the ABC code demonstration project to use the codes in contractually supported relationships.

For the ABC code demonstration project (approved in accordance with 45 CFR section 162.940) in cases where a participant in the demonstration project has contractual relationship with another entity to provide services on its behalf, the participant's concurrence also binds the contractor.

Written concurrences would be required in other circumstances. These concurrences are required from covered entities who agree to participate in a test, in order to assure that 1) participation is voluntary and 2) this authority does not circumvent the standards adoption and modification process set out in law and regulation. For example, a health plan cannot simply require all providers that submit claims to the plan to participate in testing a proposed modification.

Additionally you asked for our repose to some specific situations:

Can a health plan that registered to participate instruct its contracted software vendor to incorporate the ABC codes into software the plan uses to process claims?
Yes. The vendor should incorporate the ABC codes for the use of the participating health plan.

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If a health plan registered to participate in the ABC code demonstration contracts with another insurance company to perform claims processing or administrative services on its behalf, can that plan use the ABC codes to process those claims even if it did not register?
Yes. As long as it is performing functions under the contract with the registered health plan, the contracted insurance company would and should us the ABC codes.

Would a Preferred Provider Organization's (PPO) registration in the ABC code set demonstration also cover the practitioners that it contracts with to provide services?
Yes. The practitioners providing services under contract to the PPO would be covered by virtue of that contractual relationship.

Please feel free to contact me it you have questions on this issue. I can be reached at 410-786-4160.

Sincerely,

Jared A. Adair
Director
Office of HIPAA Standards

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EXHIBIT K – ABC CODES SUPPORT THE HHS STRATEGIC PLAN FOR FY 2003-2008

Submitted Q2 2003

General Comments:

Alternative Link and The Foundation for Integrative Healthcare are asking the Secretary of HHS for an immediate exception under the Administrative Simplification rules to allow willing trading partners to use ABC codes in all healthcare transactions in order to meet the goals of this strategic plan.

Comments Specific to Wording in the Strategic Plan:

Core Values

To deliver results that are useful both to the people and communities that are directly served by the Department's programs and to the taxpayers who pay for these programs.

Comment: Costs for healthcare services are approaching 20% of GNP and threaten the ability of the Federal Government to provide healthcare services. The Department should actively support reimbursement policies for all licensed healthcare providers to assess potential reductions in the cost of healthcare and other Department programs.

To be an accountable steward of the Department's programs and enhance the efficiency and quality of the services provided.

Comment: Healthcare administrative coding systems are the backbone of assessing and managing government sponsored healthcare and other Department programs.

To focus on health promotion and the prevention of disease and social problems, including the prevention of discrimination in the provision of health and human services.

Comment: The Department's definition of "prevention of discrimination" should include broader access to healthcare services provided by licensed alternative medicine, nursing and non-MDs.

To foster flexibility and encourage innovation in the effective delivery of health and human services programs.

Comment: A timeline is incorporated in these comments as an example of the lack of fostering flexibility and encouraging innovation within the Department. (Exhibit A)
A special historical relationship between agencies within the Department and the American Medical Association should be examined to assure that innovation is not blocked by special interest.

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To work as a single corporate entity with a "One HHS" approach to management.

Comment: Alternative Link and the Foundation for Integrative Healthcare are encouraged by this core value. A well-documented case study can be provided to the Department as an example of why a "One HHS" approach is needed. Alternative medicine, nursing and non-MD interventions offer the possibility of vastly expanding the prevention and treatment of disease and better managing healthcare dollars. A coding system (ABC codes, designed specifically for HIPAA transactions to measure the effectiveness and costs of these interventions) is currently not part of the HIPAA standard code sets. Repressing coding for all licensed healthcare interventions will have a detrimental affect on HHS plans to accomplish its objectives and will undermine the core values expressed in this Strategic Plan, especially regarding the following goals:

"PREVENTING DISEASE AND ILLNESS"

GOAL 1: Reduce the major threats to the health and well-being of Americans

Objective 1.1 Reduce the risky behaviors and other factors that contribute to the development of chronic diseases, especially diabetes and asthma

Prevention and Treatment

Support research to determine the causes of chronic diseases (such as asthma) and develop effective interventions to prevent their onset.

Comment: The Foundation for Integrative Healthcare has established relationships with 12 academic research sites willing to use ABC codes to assess the effectiveness and cost of alternative medicine, direct nursing and other integrative healthcare services.

Disseminate information about effective interventions that reduce the incidence and effects of chronic diseases, particularly asthma and diabetes.

Comment: In addition to promoting data collection by using ABC codes, the Scientific Advisory Board of the Foundation for Integrative Healthcare is connected to an indexed medical journal. The Scientific Advisory Board of the Foundation publishes results of each research project involving alternative medicine, nursing and other integrative healthcare research.

Expand the use of evidence-based chronic disease treatment protocols in health programs funded by the department.

Comment: HHS coordination between AHRQ, the NIH and especially the National Center for Complementary and Alternative Medicine will assure that funding is in place to measure the potential benefits of alternative medicine, nursing and other integrative healthcare interventions pertaining to the treatment of asthma and diabetes.

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Test the effectiveness of disease management models for the chronically ill Medicare population through disease management demonstrations.

Comment: The Department should include measuring disease management models offered by integrative approaches to treating the Medicare population.

"CLOSING THE GAPS IN HEALTH CARE"

Goal 3: **Increase the percentage of the Nation's children and adults who have access to regular health care and expand consumer choices**

Objective 3.1 Create new, affordable health insurance options

Comment: In general, alternative medicine and nursing services are less costly and less invasive than conventional, physician directed healthcare. Yet, without ABC codes, the Department is not able to measure services other than those directed by conventional physicians.

Objective 3.2 Expand the health care safety net

Comment: There are over 3 million licensed healthcare practitioners who provide services to help expand the healthcare safety net for the Nation's children and adults. The Department should assess the effectiveness of providing a broader health care safety net by expanding direct access to a broader range of licensed healthcare providers.

Objective 3.3 Strengthen and improve Medicare

Comment: Identification of less costly and less invasive treatments would improve Medicare services and strengthen its ability to provide affordable healthcare to seniors. The next generation of Medicare eligible beneficiaries was the first major population group to embrace alternative medicine.

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Objective 3.4 Eliminate racial and ethnic health disparities

Comment: Alternative medicine incorporates ethnic and traditional[327] forms of healthcare delivery already used by racial and ethnic groups.

Objective 3.5 Expand access to health care services for populations with special needs

Comment: Many ethnic populations have effectively used traditional medicine for centuries. Traditional medicines tend to cost less than conventional medicine. ABC codes can measure these interventions and compare them to conventional medical treatments.

Objective 3.6 Increase access to health services for American Indians and Alaska Natives (AI/AN)

Comment: Indigenous and Native American health interventions are included in ABC codes. A process has been developed to expand identification of Native American interventions.

"CLOSING THE GAPS IN HEALTH CARE"

Goal 3: Increase the percentage of the Nation's children and adults who have access to regular health care and expand consumer choices

Objective 3.1 Create new, affordable health insurance options

Comment: Access to healthcare benefits have a direct relationship to treatment measurements based on coding. When treatments can't be measured with codes they are effectively blocked from health insurance plan benefit design, even if these treatments would save money and offer more effective results.

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Objective 3.2 Expand the health care safety net

Comment: One of the most effective ways of expanding the healthcare safety net is by identifying effective treatment patterns through the use of coding.

Objective 3.3 Strengthen and improve Medicare

Comment: Nursing services for senior care are primarily physician directed, even when the physician never sees the patient. Physician oversight of elder care in these instances may be less effective than services managed and billed directly by nurses. These types of treatment care paths need to be measured. ABC codes have over 1,200 coded nursing interventions to help measure direct nursing services.

Objective 3.5 Expand access to health care services for populations with special needs

Previously explained.

Objective 3.6 Increase access to health services for American Indians and Alaska Natives (AI/AN)

Comment: ABC codes contain indigenous and American Indian healthcare interventions. A process to include experts from these populations to further develop coding is being managed by the Foundation for Integrative Healthcare.

"WORKING TOWARD INDEPENDENCE"

Goal 6: **Improve the economic and social well-being of individuals, families, and communities, especially those most in need**

Objective 6.2 Increase the proportion of older Americans who stay active and healthy

Comment: ABC codes include exercise, diet and nutraceuticals broadly used by integrative healthcare practitioners. The ABC codes for these interventions should be used for measuring wellness programs

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Objective 6.3 Increase the independence and quality of life of persons with long-term care needs

Comment: See comments to Objective 3.3 and add: Nursing intervention measurements should be used to assess quality of life in long-term care situations. Alternative medicine and other integrative healthcare services may reduce the Department's reliance on managing senior care with expensive drug therapies. These drug therapies tend to be administered for the convenience of the caretaker and not for the promotion of patient independence.

"IMPROVING DEPARTMENT MANAGEMENT"

Goal 8: Achieve excellence in management practices

Objective 8.4 Improve financial management

Comment: ABC codes, like UPC codes in the retail industry, improved supply chain management for healthcare services and identify potential cost savings in healthcare delivery.

Objective 8.5 Enhance the use of electronic commerce in service delivery and record keeping

Comment: ABC codes were designed to offer multiple levels of information, including reference to the scope of practice for each provider in each state to avoid fraudulent billing practices.

Objective 8.6 Achieve integration of budget and performance information

Comment: The insurance industry uses budget and performance measurements when it underwrites the cost of healthcare premiums. The Department should review insurance industry systems to more rapidly achieve this goal.

Objective 8.7 Reduce regulatory burden on providers and consumers of HHS services

Comment: Naming ABC codes under HIPAA will help the Department reach this objective quickly. ABC codes were designed to provide state scope of practice information to reduce the regulatory burden of fraudulent claims on providers and consumers of HHS services.

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Additional actions:

The Secretary should immediately create an exception, as authorized under HIPAA Administrative Simplification, to allow the industry to use ABC codes until they are named under HIPAA. This exception should allow all willing trading partners to use ABC codes for at least three years. The issue of coding for alternative medicine, nursing and non-MD services is of critical importance if the Department is to reach its goals and objectives. Alternative Link and/or The Foundation for Integrative Healthcare therefore request that formal presentations about ABC codes be scheduled with:

The Public Health Council (consisting of Agency heads or deputies) meets quarterly to ensure coordination and communication across public health and other HHS agencies for the purpose of sustaining and improving the nation's public health infrastructure.

The Data Council advises the Secretary on data policy and serves as a forum for consideration of those issues. The council also coordinates the Department's data collection and analysis and ensures effective long-range planning for surveys and other investments in major data collection.

The Healthy People 2010 steering committee includes all HHS Operating Divisions/Agencies, and the Healthy People Consortium is comprised of 650 national and state organizations. Together, these bodies coordinate, advise, and plan activities for measuring and implementing health and social services throughout the Department.

The Secretary's Council on National Health Promotion and Disease Prevention serves to further advise the Department with regard to the development, monitoring, measurement, and implementation of Healthy People 2010.

The Quality Interagency Coordination Task Force (QuIC) ensures that all federal agencies involved in purchasing, providing, studying, or regulating health care services are working in a coordinated way toward the common goal of improving quality of care.

The purpose of presentations to these audiences is to assure that each department understands the benefits of using ABC codes in conjunction with other administrative code sets to meet the goals expressed in this strategic document.

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External Coordination

Based on Appendix A of the Strategic Plan regarding agencies that will coordinate to achieve the goals of HHS, the following agencies should understand and be aware of the capacity of ABC codes to support the Department's core values, goals, and objectives:

CMS, HIPAA, AHRQ, FDA, AoA, ACF, HRSA, IHS, SAMHSA, Office of Minority Health, ACF, Administration for Native Americans, NIH, Surgeon General's Office, OPHS, CDC, ASPE, President's Council for Physical Fitness and Sports, OS, OIG, IHS, ACF, NLM, and ASBTF

Alternative Link and The Foundation for Integrative Medicine support the core values, goals, and objectives in this strategic plan. Both organizations are available to HHS or any external coordinating bodies to explain how ABC codes for alternative medicine, nursing and non-MD services were developed to help expand quality initiatives and evidence-based medicine to meet the strategic initiatives proposed in this plan. A tutorial about the ABC codes, Alternative Link's participation in and initiatives with NCVHS and other HIPAA organizations to promote ABC codes is provided as part of these comments and are available to any interested parties. Please request these documents via e-mail: melinna.giannini@alternativelink.com or by calling 505-875-0001.

Dr. David Riley of The Foundation for Integrative Healthcare is also available to explain the importance of ABC codes to academic research. He can be contacted by calling 505-983-0546 or by e-mail: dsriley@integrativemed.org

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EXHIBIT L – ABC CODES SUPPORT THE NCCAM STRATEGIC PLAN: 2005-2009

To which public health problems can complementary and alternative medicine make important contributions and the biggest impact?

Complementary and alternative medicine (CAM) can make important direct and indirect contributions to nearly all of the strategic objectives identified in the HHS strategic plan at http://aspe.hhs.gov/hhsplan/ (and listed below).

GOAL 1: Reduce the major threats to the health and well being of Americans

Objective 1.1
Reduce behavioral and other factors that contribute to the development of chronic diseases.
(Example: Offer the Dean Ornish or similar programs instead of, or in conjunction with, conventional care for reversing heart disease.)
Objective 1.2
Reduce the incidence of sexually transmitted diseases and unintended pregnancies.
(Example: Promote sex or abstinence education where proven cost-effective.)
Objective 1.3
Increase immunization rates among adults and children.
(Example: Make electronic health records accessible by conventional, complementary and alternative practitioners, so immunization coaching can be delivered by more than just conventional practitioners.)
Objective 1.4
Reduce substance abuse
(Example: Promote spiritually based care, such as 12-step programs, where proven cost-effective.)
Objective 1.5
Reduce tobacco use, especially among youth
(Example: Provide culturally and age competent health educators to populations at risk of or engaged in tobacco use.)
Objective 1.6
Reduce the incidence and consequences of injuries and violence.
(Example: Promote faith-based and community initiatives focused on reduction of injuries and violence in at risk populations.)

GOAL 2: Enhance the ability of the Nation's health care system to effectively respond to bioterrorism and other public health challenges

Objective 2.1
Build the capacity of the health care system to respond to public health threats in a more timely and effective manner, especially bioterrorism threats.
(Example: Capture data from the estimated 1.4 billion CAM office visits in addition to the estimated 1.1 physician office visits, to fully integrate CAM into the national health information infrastructure and better support early identification of public health threats.)

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Objective 2.2
Improve the safety of food, drugs, biological products, and medical devices.
(Example: Improve outcomes research on CAM, then increase access to safe, effective and cost-effective CAM interventions to increase competitive pressures on conventional interventions and thereby drive up quality while pushing down costs.)

GOAL 3: Increase the percentage of the Nation's children and adults who have access to health care services, and expand consumer choices

Objective 3.1
Create new, affordable health insurance options.
(Example: Implement coding for CAM practices (e.g., using ABC codes for alternative medicine, nursing and other forms of integrative healthcare) to improve health insurance benefit plan design, managed care and provider contracting, utilization and clinical practice management, claims processing, outcomes research and a variety of actuarial analyses. Promote CAM in high cost CAM-responsive diagnoses to reduce the total cost of care and thereby stabilize or reduce health insurance premiums. Provide incentives to increase the availability of health insurance products that include CAM coverage and reimbursement. Facilitate free market competition among conventional, complementary and alternative care and related insurance products to enhance the affordability of health insurance.)
Objective 3.2
Strengthen and expand the health care safety net.
(Example: Free money for the uninsured or underinsured by extending measurement, analysis and reporting tools into CAM to better identify cost-saving best practices among conventional, complementary and alternative approaches to care.)
Objective 3.3
Strengthen and improve Medicare.
(Example: Provide more preventive and wellness-oriented services in demonstration programs, e.g., provide educational programs on holistic self-care for the chronically ill.)
Objective 3.4
Eliminate racial and ethnic health disparities.
(Example: Increase access to culturally competent care such as Oriental medicine, indigenous medicine, Ayurvedic medicine, curanderas, etc.)
Objective 3.5
Expand access to health care services for targeted populations with special health care needs.
(Example: Increase access to unconventional interventions and non-MD caregivers in rural, impoverished and other non-mainstream areas less likely to attract and/or retain conventional physicians.)

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Objective 3.6
Increase access to health services for American Indians and Alaska Natives (AI/AN).
(Example: Increase access to culturally competent caregivers such as medicine men.)

GOAL 4: Enhance the capacity and productivity of the Nation's health science research enterprise

Objective 4.1
Advance the understanding of basic biomedical and behavioral science and how to prevent, diagnose, and treat disease and disability
(Example: Expand research into unconventional, non-MD and non-mainstream areas, such as spiritual healing, therapeutic touch, etc. Advancement of scientific understanding in these areas may shed light on unexplained phenomena in the biomedical and behavioral arenas.)
Objective 4.2
Accelerate private sector development of new drugs, biologic therapies, and medical technology.
(Example: Support private sector initiatives in development of new CAM interventions independent of and/or in conjunction with development of new conventional technologies, so technologies co-evolve.)
Objective 4.3
Strengthen and diversify the pool of qualified health and behavioral science researchers.
(Example: Ensure health and behavioral researchers include individuals without biases toward conventional Western medicine.)
Objective 4.4
Improve the coordination, communication, and application of health research results.
(Example: Establish health-related data standards for clinical and administrative vocabularies associated with CAM (e.g., ABC codes) to facilitate scientific measurement, analysis and reporting.)
Objective 4.5
Strengthen the mechanisms for ensuring the protection of human subjects and the integrity of the research process. (Example: Ensure the same protections exist for human subjects interested in cutting edge and "off-label" CAM interventions as for cutting edge and "off-label" conventional interventions.)

GOAL 5: Improve the quality of health care services

Objective 5.1
Reduce medical errors.
(Example: Ensure patient health records include CAM treatments to avoid medical errors and adverse reactions associated with a lack of awareness of unconventional care.)
Objective 5.2
Increase the appropriate use of effective health care services by medical providers.
(Example: Identify CAM-responsive diagnoses and best CAM practices to ensure patients get the best possible care, whether that care is conventional, complementary and/or alternative.)

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Objective 5.3
Increase consumer and patient use of health care quality information.
(Example: Ensure CAM coding is available in consumer-driven health plans and that resulting data are warehoused, analyzed and reported in a manner that gives consumers access to care options and the outcomes associated with each of those options.)
Objective 5.4
Improve consumer and patient protections.
(Example: Measure the safety, efficacy and cost-effectiveness of CAM to ensure CAM "labeling" is at least as reliable as "labeling" for conventional drugs, devices, biologics, etc.)
Objective 5.5
Accelerate the development and use of an electronic health information infrastructure.
(Example: Fill gaps in the national health information infrastructure and HIPAA codes in the areas of CAM, nursing and other integrative healthcare interventions that leave the practices of >3 million licensed healthcare practitioners inadequately coded and prevent data capture on more than 1.4 billion episodes of care each year.)

GOAL 6: Improve the economic and social well being of individuals, families, and communities, especially those most in need

Objective 6.1
Increase the proportion of low-income individuals and families, including those receiving welfare, who improve their economic condition.
(Example: Address through culturally competent education those health conditions associated with lower earning potential, e.g., obesity, pregnancy, substance abuse, etc.)
Objective 6.2
Increase the proportion of older Americans who stay active and healthy.
(Example: Provide self-care guidance on exercise, diet, stress management, recovery from substance abuse, etc., to elderly Americans.)
Objective 6.3
Increase the independence and quality of life of persons with disabilities, including those with long-term care needs.
(Example: Provide interventions such as yoga therapy to disabled individuals such as post-polio sufferers.)
Objective 6.4
Improve the economic and social development of distressed communities.
(Example: Increase community self-reliance through support of evidence-based faith-based, community and ethnic care.)
Objective 6.5
Expand community and faith-based partnerships.
(Example: Identify through CAM research initiatives cost-effective community and spiritual care.)

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GOAL 7: Improve the stability and healthy development of our Nation's children and youth

Objective 7.1
Promote family formation and healthy marriages.
(Example: Identify and promote cost-effective faith-based and community initiatives that incorporate CAM, e.g., spiritual guidance, sex and abstinence education, etc.)
Objective 7.2
Improve the development and learning readiness of preschool children.
(Example: Identify the diet and nutritional supplements that support healthy development and learning readiness of preschool children.)
Objective 7.3
Increase the involvement and financial support of non-custodial parents in the lives of their children.
(Example: Identify cost-effective faith-based, community and behavioral health initiatives that foster better parenting.)
Objective 7.4
Increase the percentage of children and youth living in a permanent, safe environment.
(Example: Expand the base of healthcare practitioners able to recognize unhealthful living conditions by expanding public health education to CAM practitioners who serve rural, impoverished and ethnic populations.)

GOAL 8: Achieve excellence in management practices

Objective 8.1
Create a unified HHS committed to functioning as one Department.
(Example: Work toward an integrative rather than segmented (conventional, complementary and alternative) approach to health and human services.)
Objective 8.2
Improve the strategic management of human capital.
(Example: Ensure complete, accurate and precise digitized information—including information on CAM-- is available to support health research and health policymaking).
Objective 8.3
Enhance the efficiency and effectiveness of competitive sourcing.
(Example: Broaden the competitive pool by considering CAM-related vendors.)
Objective 8.4
Improve financial management.
(Example: Support best [i.e., most cost-effective] practices in Medicare, Medicaid and other government-sponsored health plans by measuring the economic and health outcomes of conventional, complementary and alternative approaches to care, using ABC codes in conjunction with older medical code sets.)
Objective 8.5
Enhance the use of information technology in service delivery and record keeping.
(Example: Support the addition of ABC codes to the HIPAA code sets and the NHII to ensure digitized information on CAM is available to support the financing, administration and delivery of CAM care.)

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Objective 8.6
Achieve integration of budget and performance information.
(Example: Support performance and outcomes-based payment systems by capturing data on the comparative outcomes of conventional, complementary and alternative approaches to care.)
Objective 8.7
Reduce regulatory burden on providers and consumers of HHS services.
(Example: Increase digitization of information and technology-aided access to information in areas of healthcare of greatest interest to providers and consumers of HHS services, e.g., payors, information technology companies, provider organizations, practitioner associations and industry developers interested in consumer-driven healthcare and CAM.)

General Comments:

CAM can improve healthcare accessibility, quality and cost-management. It may offer more cost-effective practices than conventional care for some health conditions and may, therefore, reduce the cost of government and privately sponsored health plans.

With the number of CAM office visits exceeding the number of physician office visits, digitizing information on CAM-related episodes of care has become essential to public health surveillance.

Digitized information on the economic, health, health-related quality of life and patient satisfaction outcomes of care is also essential to proper function of the national health information infrastructure, as well as to profitable management of individual, employer-sponsored, workers' compensation, disability, long-term, property and casualty and other insurance programs.

Healthcare cost increases (as measured from conventional medical data) throughout the country and across industry sectors have devastating implications for the health of Americans and the U.S. economy.

For the last two decades, the rate of medical inflation has averaged twice that of general inflation. In the last two years, health insurance premiums have grown more than five times the rate of general inflation (according to the National Health Care Influencers' Assembly at the World Health Care Congress).

The U.S. Census Bureau reported the number of uninsured increased 2.4 million in 2002 (about a 6% increase over 2001), and the total number of uninsured reached 43.6 million.[328] About 34 million more Americans had inadequate insurance.[329]

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Naturally, a growing number of employers are choosing to drop health benefits entirely or transfer additional costs to employees because healthcare benefits are increasingly difficult to justify economically. As employers withdraw or reduce job-based health benefits, the financial burden of healthcare on individuals and the public sector further escalates. According to the Center for Practical Health Reform, a 1% annual decrease in the number of Americans with employer-sponsored coverage translates to a 4% annual increase in the number of uninsured.

CPT[330] codes—the medical coding standard— represent the practices of an estimated 800 thousand physicians (and an estimated 1.1 billion annual episodes of care).[331] These code sets do not adequately or precisely characterize alternative medicine, nursing and other integrative healthcare practices. Therefore, the care provided by more than 3 million licensed integrative healthcare practitioners (offering an estimated 1.4 billion episodes of care[332]) remains largely invisible to health policymakers. Measuring this care is critical to identifying cost-effective options to conventional medical care.

What should NCCAM's role be, if any, in enabling integration of CAM therapies into mainstream conventional medical care?

NCCAM should take the lead in identifying high cost CAM-responsive diagnoses and related CAM interventions that, properly managed, can improve medical cost ratios (MCRs).

NCCAM should also ensure the administrative costs associated with the financing, administration and delivery of CAM are at least comparable to those associated with conventional care. ABC codes, practitioner identifiers, relative value units and legal practice guidelines for top CAM practices are essential to this effort. For example, in health plans, these codes, identifiers, RVUs and guidelines make processing of CAM insurance claims as easy as processing of claims for conventional medical care. Without these CAM tools, health plans could not tell whether a specific intervention delivered by a specific caregiver in a specific state was legal or not. This would kick the associated insurance claim into manual review and would create a financial disincentive to coverage and reimbursement of the CAM intervention (on the basis of higher administrative costs) even the care itself was more cost-effective than conventional care.

How should NCCAM's research training and career development programs be designed to facilitate its research goals?

NCCAM should gain expertise in the benefits offered by a complete national health information infrastructure. The organization should be able to describe CAM practitioner education and core competencies by the interventions each practitioner is trained to use. NCCAM should gain insurance industry expertise in 1) health insurance benefit plan design, 2) managed care and provider contracting, 3) utilization and clinical practice management, 4) claims processing, 5) integrative healthcare outcomes research, 6) actuarial analyses, 7) fraud and abuse issues, 8) HIPAA transaction and code set standards, 9) insurance underwriting and 10) other business processes essential to integrating the best practices from CAM into mainstream healthcare.

What are the knowledge gaps, specific themes, content areas, and/or key audiences that outreach should focus on?

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NCCAM knowledge gaps center around insurance industry business processes and data collection methods. A stronger connection to this sector would allow NCCAM to expand its research capabilities and help payors gain information on high cost CAM-responsive diagnoses and cost-effective CAM practices that could significantly improve medical cost ratios.

NCCAM should identify the best practices among conventional, complementary and alternative care to support consumer-driven healthcare and to expand public access to higher quality care at a reduced cost.

Content areas should include coding and a clear understanding of how a robust national health information infrastructure is essential to good research, effective management and efficient commerce.

A reasonable starting point for resolving the U.S. healthcare crisis is the development of

1. complete, accurate, precise, open and impartial health-related data standards,

2. shared communication protocols, and

3. universally compatible information technology platforms.

A fully-evolved national health information infrastructure (NHII) would improve the quality of care, support public health surveillance, and enhance the efficiency of the U.S. healthcare system.[333]

NCCAM should publicly endorse ABC codes, since these are increasingly viewed as an essential health-related data standard[334] and could serve as a veritable "poster child" for the public-private collaborations viewed as necessary to facilitate advances in the NHII.

They are urgently needed 1) to ensure the 1.4 billion patient encounters with integrative healthcare practitioners are not lost to those commissioned with securing early warnings of bioterrorism and other health threats 2) to support the adoption of best practices across the nation and 3) to identify those practices that can improve medical cost ratios.

In a third quarter conference, "National Health Information Infrastructure 2003, Developing a National Action Agenda for NHII,"[335] HHS invited a broad base of health information technology stakeholders to develop a consensus for national action in eight key areas:

1. Research and Population Health
2. Homeland Security
3. Consumer Health
4. Financial Incentives
5. Safety and Quality
6. Standards and Vocabulary
7. Architecture

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8. Privacy and Confidentiality

The Standards and Vocabulary Track focused on how to promote development, ongoing maintenance, and widespread use of health-related data content and transmission standards. The track committed to look beyond the HIPAA administrative standards and focus on additional data standardization to support clinical care, public health and research.[336]

The track opened with discussion of the ideal goal/state: [337]

> "Health-related data would be collected once and then used for all appropriate health-related functions. Public health surveillance would occur automatically as a by-product of healthcare. Statistical and billing data would be generated automatically from clinical data. Clinical data collected at different locations would be aggregated for research and other purposes. Data would be geo-coded at the point of capture. Standardization would facilitate decision support, aggregate and trend analyses, and comparison between institutions and geographic areas. Because the same standards are required by different Federal, state, and local agencies, costly duplicate data collection and translation would be avoided.
>
> A robust information model would describe the entities that collect or use health data and the relationships among them, thus defining the universe that requires standardization. Standard document architectures, messaging formats, algorithms, guidelines, and vocabularies would reflect the information model and be interlocking, e.g., a standard vocabulary or a set of standard allowed values would be established for every data element or message field that requires one.
>
> Data element, messaging, vocabulary, and identifier standards would address all the contexts in which health data were collected and used, reflecting the data needs of all types of healthcare professionals, the public health workforce, patients, and the general public and of the full range of organizations that create or use health data.
>
> The organizations responsible for the maintenance and quality of specific health data standards would coordinate their activities to avoid duplicate or conflicting standards and provide a single point of entry for requests for changes and additions.

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Standards would be maintained and their quality assessed through an open process that is responsive to the health data needs of the full range of stakeholders.

> If and when the federal government or private foundations funded the development of health vocabularies, these efforts would be designed to complement, extend, or improve existing standards and not to duplicate or compete with them."

Do you have other comments?

ABC codes fill critical gaps in medical coding systems and the NHII so that all approaches to healthcare can be objectively tracked, analyzed and managed. This is essential for more than just administrative simplification in research, management and commerce. It is essential for the advancement of evidence-based care.

For example, used in conjunction with medical code sets, ABC codes support comparisons of the economic and health outcomes of conventional, complementary and alternative care. In doing so, the codes help identify best practices. This gives health industry decision-makers critical insight about the cost-effectiveness of potentially competing approaches to care—insight that can serve as a basis for better case management, coverage and reimbursement policies.

In an era of limited resources and relatively unlimited demand, knowing what interventions work best and cost least is essential to getting a greater number of Americans the care they need. NCCAM should focus on obtaining and disseminating this information to best serve the public.

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EXHIBIT M – FAQS SUPPORT ABC CODE TRAINING

Frequently Asked Questions

1. ***What are ABC codes?***
   ABC codes are 5-character alphabetic symbols that represent thousands of integrative healthcare products and services.

2. ***What is integrative healthcare?***
   Integrative healthcare is care that incorporates the best approaches from conventional, complementary and alternative medicine.

3. ***What kinds of care are represented by ABC codes?***
   The codes reflect the care delivered by acupuncturists, Ayurvedic doctors, behavioral healthcare workers, bodyworkers, chiropractors, culturally competent caregivers (for ethnic and minority healthcare), holistic dentists, holistic physicians, homeopaths, indigenous medicine, massage therapists, mental healthcare practitioners, midwives, naturopaths, nurses, nutritionists, Oriental medicine practitioners, osteopaths, social workers, somatic educators, spiritual and prayer based healers and others.

4. ***Will other areas of healthcare be addressed by ABC codes?***
   Yes. ABC codes will soon reflect additional types of care delivered by dental hygienists, occupational therapists, pharmacists and others.

5. ***Why are ABC codes essential?***
   Older medical code sets have significant gaps. They do not adequately describe or reflect the care delivered by more than 3 million licensed healthcare practitioners and millions of other caregivers.

6. ***Why do gaps in older medical code sets matter?***
   Gaps in codes compromise the ability of the nation, the U.S. healthcare system, healthcare organizations and practitioners to get the right care to the right people at the right time and place, at a rational cost.

7. ***How are codes generally used?***
   Codes are used to help all participants in the healthcare system digitize information that is essential for critical business processes so that these processes become more cost-effective and reliable. Codes also improve the national health information infrastructure so that decision-makers have the information they need readily available to make good decisions or take appropriate actions.

8. ***Who uses codes and in what specific ways?***
   Virtually every participant in the healthcare system uses codes for some critical purpose. For example, practitioners use codes for medical record keeping, practice management and billing. Health plans use codes for processing insurance claims and for designing and managing benefits. Researchers use codes to identify what care works best. Policymakers use codes to understand what is best for the nation and to make public policy decisions.

9. ***What are the risks of incomplete, inaccurate or imprecise codes?***
   Inadequate codes prevent decision-makers from having essential health-related information at their fingertips.

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10. ***What is the biggest benefit of using ABC codes?***
    ABC codes improve the healthcare industry and healthcare operations in the same manner that universal product codes (UPCs/bar codes) improved the retail industry and retail operations. They allow many essential business processes (such as forecasting, practice management, insurance billing, claims processing and third party reimbursement) to be automated.

11. ***How do ABC codes help automated business processes?***
    ABC codes digitize information to simplify data collection, analysis and reporting.

12. ***What other coding-related information is available from Alternative Link?***
    In addition to ABC codes, Alternative Link also offers 1) practitioner modifiers that identify the types of healthcare practitioners who could deliver the care reflected by the codes, 2) relative value units (RVUs) that reflect the financial worth of integrative healthcare interventions, and 3) legal practice guidelines that establish the legality of delivered care on a per intervention, per practitioner and per state basis. Together, ABC codes, practitioner modifiers, RVUs and legal practice guidelines help health industry participants identify the best practices among conventional, complementary and alternative approaches to care. They help make these best practices available to a greater number of Americans at a more affordable price.

13. ***Why are practitioner modifiers important?***
    Practitioner modifiers help identify who delivered care and, used in conjunction with ABC codes and legal practice guidelines, establish whether caregivers are legally authorized and properly trained to deliver a specific intervention.

14. ***How are practitioner modifiers used?***
    The 2-character practitioner modifiers are attached to the end of the 5-character ABC codes to convey the type of practitioner who provided care. The resulting 7-character "code + modifier" is used in the same forms, data fields, software applications, information systems and business processes as older medical codes and their modifiers—except that the ABC code and modifier can be linked to state-specific legal practice guidelines to help automatically ensure care was in compliance with statutes, administrative regulations and case law.

15. ***What is an RVU and why are RVUs important?***
    RVUs establish the financial worth of specific interventions in relation to other interventions and support health economics studies, health insurance benefit plan design, managed care and provider contracting, utilization and clinical practice management, claims processing, outcomes research and a variety of actuarial analyses.

16. ***How are RVUs used?***
    RVUs are typically multiplied by regional conversion factors (CFs) to establish a dollar value for a specific intervention. For example, an RVU of 5.2 would be multiplied by a conversion factor of $10.00 to establish a baseline value of $52 for the corresponding service. For another service, the RVU might be 12.4 and, with the same conversion factor of $10.00, the baseline value would be $124.

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17. ***What are conversion factors?***
    Conversion factors are monetary multipliers that convert relative value units (RVUs) into payment amounts. CFs are reported as dollar figures. They reflect healthcare practice costs in a particular office, group practice, healthcare institution or region. They may take into account cost-drivers such as overhead (e.g., malpractice insurance), rent, salaries and the cost of living. For example, the CF in a West Coast region might be $36.00 while a CF in another region of the country might be $27.00.

18. ***How are conversion factors used?***
    Conversion factors are multiplied by relative values to support cost accounting, resource allocation studies, pricing and fee schedule development, practitioner compensation analyses, utilization and case management; health economics studies, capitation cost analyses and managed care contract analyses.

19. ***Why are legal practice guidelines important?***
    In contrast to the laws for conventional medical doctors, the laws for integrative healthcare practitioners vary by state. Practitioners, provider organizations and health plans need to know on a per intervention, per practitioner and per state basis whether care delivered by a specific type of integrative healthcare practitioner is within that practitioner's legal scope of practice and professional competencies.

20. ***How are legal practice guidelines used?***
    Practitioners can use legal practice guidelines to identify healthcare products and services they can legitimately provide to patients and avoid malpractice or fraudulent billing charges. Provider organizations and health plans can use the same legal practice guidelines for credentialing and contracting—and to avoid being named in malpractice or fraud cases.

21. ***Are ABC codes compatible with other codes and systems in use today?***
    Yes. ABC codes work side-by-side with other codes. ABC codes fit into the same business forms, data fields, software applications, information systems and business processes as older medical codes such as CPT, HCPCS II, HCPCS III (local Medicaid codes) and CDT codes.

22. ***Who can use ABC codes?***
    Anyone can use ABC codes for research, management and manual or paper-based commerce. These uses of code sets are unregulated and fall outside of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For electronic commerce, which is a federally regulated use of code sets under HIPAA, ABC codes may be used by any of more than 10,000 entities that secured rights to use the codes under a section of the Code of Federal Regulations known as 45 CFR 162.940, as well as by millions of their contractual trading partners.

23. ***What is the Health Insurance Portability and Accountability Act of 1996 (HIPAA)?***
    HIPAA is federal legislation, passed in 1996, that includes an "Administrative Simplification" section and requirements for development of standardized transactions and code sets to support electronic data interchange (EDI) in U.S. healthcare system.

24. ***Who is responsible for Administrative Simplification under HIPAA?***
    Ultimately, the U.S. Department of Health and Human Services (HHS). Title II of HIPAA (the section that required administrative simplification) required HHS to establish 1) national standards for electronic healthcare transactions and 2) national identifiers for providers, health plans and employers.

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25. ***What is the purpose of HIPAA transaction and code set standards?***
    The objective of the HIPAA transaction and code set standards is to improve the efficiency and effectiveness of the nation's healthcare system by encouraging the widespread use of electronic data interchange (EDI) in healthcare. For more information, please visit (http://www.cms.hhs.gov/hipaa/).

26. ***What kinds of health industry organizations and professionals registered to secure rights to use ABC codes in electronic commerce?***
    Registrants included major employers with self-funded health plans; government and commercial health plans; integrative delivery networks, hospital systems and community hospitals; sub-acute care facilities including skilled nursing facilities, rehabilitation centers, integrative healthcare clinics and integrative healthcare practices; academic research centers and think tanks; healthcare information technology companies and consultancies; third party administrators and claims management companies; holistic physicians; integrative, complementary and alternative medicine practitioners; nurses and hundreds of other categories of health industry stakeholders.

27. ***Who else has rights to use ABC codes?***
    Anyone can use ABC codes for research, management and manual commerce. Those who do business with registrants can also use ABC codes in electronic commerce.

28. ***When and why did organizations and individuals register to secure their rights to use ABC codes in electronic commerce?***
    Organizations and individuals registered between January 16th and May 29th of 2003 to secure their rights to use ABC codes in electronic commerce beyond the October 16, 2003, HIPAA transaction and code set compliance date.

29. ***Who established the registration requirement?***
    The registration requirement was recommended by the Office of HIPAA Standards and was subsequently established by the Secretary of the U.S. Department of Health and Human Services (HHS).

30. ***Why did HHS require registration?***
    HHS required registration for two reasons. First, in permitting use of ABC codes under HIPAA, HHS needed to comply with the section of the Code of Federal Regulations (45 CFR §162.940) that required identification of "trading partners" who planned to use ABC codes, as well as their geographic locations. Second, the registration gave HHS a way to make ABC codes quickly and broadly available under HIPAA.

31. ***Why did HHS authorize ABC codes as a HIPAA-compliant code set under a special section of the Code of Federal Regulations (45 CFR §162.940) rather than in the same manner in which it authorized ICD-9, CPT, HCPCS II and CDT codes?***
    HHS authorized HIPAA-compliant use of ABC codes under 45 CFR §162.940 because—unlike the older medical code sets—ABC codes were relatively new to the U.S. healthcare system, and no objective, transparent and timely evaluation and naming process had been established for such innovations.

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32. ***What, exactly, did 45 CFR §162.940 allow?***
    45 CFR §162.940 gave the Secretary of HHS power to establish HIPAA-compliant uses of proposed modifications to the HIPAA standards while data was collected to support the necessity of those modifications. Under this section of the Code of Federal Regulations, the Secretary extended the uses of ABC codes from research, management and manual commerce (which are unregulated) into electronic commerce (which are regulated under HIPAA).

33. ***What is the result of the Secretary's establishing ABC codes as HIPAA-compliant under 45 CFR §162.940?***
    The Secretary's authorization of ABC codes under 45 CFR §162.940 ensures broad based availability of ABC codes as an optional but not mandatory HIPAA-compliant code set. It also supports the collection of real world data on the cost-benefit of ABC codes in electronic commerce.

34. ***When will ABC codes become mandatory rather than optional?***
    Alternative Link anticipates ABC codes will become mandatory well before the third quarter of 2005.

35. ***What sort of HIPAA designation will ABC codes get when all is said and done?***
    The codes are likely to be named as a subset of a pre-existing mandatory HIPAA code set (such as HCPCS II, which already incorporates code sets developed by outside entities) or as a freestanding and mandatory HIPAA code set.

36. ***What specific organizations and individuals registered to use ABC codes?***
    Alternative Link does not identify individual registrants without their permission, since many registrants had strategic purposes for adopting ABC codes and wanted to maintain anonymity until they fully deployed the codes in strategically advantageous ways. However, nearly all registered healthcare practitioners authorized their names to be provided to third party payors and to provider organizations.

37. ***Why did healthcare practitioners agree to be identified to payors and provider organizations?***
    Healthcare practitioners wanted to be identified so that—once these payors and providers established coverage and reimbursement policies for the practitioners' areas of professional practice—the practitioners would be able to conduct electronic transactions with those "trading partners" using ABC codes.

38. ***When will we hear more about registrants and their trading partners?***
    Over the next 3 to 12 months, many industry-leading organizations that have non-disclosure agreements with Alternative Link will make public announcements about their planned use of ABC codes. When this happens, Alternative Link will request permission to post this information to www.alternativelink.com. Please continue to visit this site regularly to keep current on organizations that are using ABC codes.

39. ***Who will be making announcements?***
    Public announcements are planned by scores of national and regional health insurance, information technology, claims management, utilization review, research and related organizations.

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40. ***When should I be prepared to use ABC codes and why?***
Now. Practitioners and integrative healthcare clinics should consider using ABC codes immediately because the codes, practitioner modifiers (identifiers), relative value units (RVUs based on ABC codes) and legal practice guidelines help these entities do a better job of 1) developing pricing, 2) understanding which types of care are profitable, 3) identifying cost-effective treatment patterns, 4) documenting patient encounters and 5) avoiding fines associated with fraudulent billing.

41. ***Do you have any tools to help a practitioner or clinic get started?***
Customized *Superbills for Integrative Healthcare* and more than 600 profession-specific and state-specific versions of the *Practitioner's Guide to Billable Interventions Using ABC Codes* are available to help you completely, accurately and precisely document the care you have delivered. These tools list the ABC codes that practitioners may legally bill in their states. (CPT® or HCPCS II codes can be added to Superbills to support better practice management while facilitating reimbursement from insurance companies that may still require use of these older medical codes.) Also, a publication known as *Relative Values for Integrative Healthcare Using ABC Codes* is available to support pricing, practice management and managed care contracting.

42. ***Which companies are paying claims based on ABC codes?***
Lovelace Sandia Health System in New Mexico has been paying ABC coded claims since 1999, under its various corporate forms. Numerous other payors are in the process of implementing the ABC codes but have not yet formally announced their plans.

43. ***When can I start using ABC codes?***
You can use ABC codes immediately for research, management and non-electronic commerce, since these uses are not regulated or governed by HIPAA. Anyone can use ABC codes immediately for electronic commerce if they or at least one of their business partners registered for rights to use ABC codes under HIPAA.

44. ***How do I register for rights to use ABC codes under HIPAA?***
At this point, you will need to petition rather than register. (HHS cut off the registration period on May 29, 2003.) To petition, please visit www.alternativelink.com/ali/ue/petitions.asp

45. ***Do I have any options other than petitioning?***
Yes, if you did not register, you can still find a business partner who did, and gain rights to use ABC codes in electronic commerce through them. Also, anyone can use ABC codes for research, management and non-electronic commerce without registering, since these uses of ABC codes are not regulated or governed by HIPAA.

46. ***What will happen with my petition for rights to use ABC codes under HIPAA?***
Alternative Link will forward your petition to HHS. HHS will determine whether you will be granted rights to use ABC codes in electronic commerce.

47. ***How can I expedite my petition?***
If you would like your request expedited, please call the Director of the Office of HIPAA Standards at the Centers for Medicare and Medicaid Services (877-267-2323) and also please notify Alternative Link at UserRegistration@AlternativeLink.com.

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48. ***How do I file insurance claims using ABC codes?***
The codes can be used on standard CMS-1500 and CMS-1450 forms used for filing healthcare insurance claims. ABC codes fit in the procedure code sections of both forms.

49. ***Can I get the ABC codes off the web site?***
You cannot get the codes off the web site, but you can order coding resources there, such as customized *Superbills for Integrative Healthcare*, the *ABC Coding Manual for Integrative Healthcare* (which includes more than 4,000 codes for services and supplies), the *Practitioner's Guide to Billable Interventions Using ABC Codes*, and *Relative Values for Integrative Healthcare Using ABC Codes.*

50. ***What is the difference between** the ABC Coding Manual for Integrative Healthcare and the Practitioner's Guide to Billable Interventions Using ABC Codes?*
The *ABC Coding Manual for Integrative Healthcare* includes more than 4,000 ABC codes, without identifying which services and/or supplies a specific practitioner type can legally deliver in a given state. The *Practitioner's Guide to Billable Interventions Using ABC Codes* lists only the ABC codes for services and supplies that are within a practitioner's legal scope of practice in a specified state.

51. ***What is the "Specialized Training Addendum"?***
Accompanying any *Practitioner's Guide to Billable Interventions Using ABC Codes* is a *Specialized Training Addendum* that includes a list of coded procedures that require additional certification and/or training. These codes may be used if a practitioner can document the required certification and/or training.

52. ***Will I still need ABC codes if someone else (such as the American Medical Association or the Centers for Medicare and Medicaid Services) starts coding integrative healthcare products and services?***
Yes, either directly or indirectly, you will still need ABC codes and other coding-related solutions.

53. ***Why would I still need ABC codes if the AMA developed CPT codes or CMS developed HCPCS II or ICD-10-PCS codes for integrative healthcare?***
Only ABC codes are linked to integrative healthcare practitioner modifiers (identifiers), RVUs and legal practice guidelines, since this is a patented process.

54. ***Other than the patent, why would ABC codes be used instead of CPT or HCPCS II codes?***
ABC codes provide more complete, accurate and precise descriptions of integrative healthcare interventions and eliminate potential biases in coding that could prevent scientific comparisons of the economic and health outcomes of conventional, complementary and alternative approaches to care.

55. ***How could older medical code sets introduce biases in coding?***
Older medical coding authorities maintain prevalence requirements for assignment of payable codes. That is, the applicant for a new code that could be considered payable by health plans must prove that the intervention is already widely used, despite the fact that widespread use often depends on the preexistence of coding and third party payment. Older medical coding authorities also require that care being considered for coding be subjected to "technology assessment" standards established by conventional Western medical doctors. While numerous integrative healthcare interventions are safe and effective, relatively few could be properly assessed using Western ideas alone and might therefore fail to meet Western physician-driven standards. This would result in Western biases in coding that would limit the ability of entire categories of caregivers to participate in mainstream healthcare and would also prevent scientific comparisons of the economic and health outcomes of conventional, complementary and alternative approaches to care.

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56. ***How are ABC codes developed?***
ABC codes are developed in an open and unbiased manner that reflects the official training, practices, vocabularies and terminologies of the integrative healthcare professions.

57. ***How do ABC codes get assigned?***
Anyone may submit an ABC Terminology and Code Request Form to Alternative Link or The Foundation for Integrative Healthcare (FIHC) to suggest a new or modified ABC code. FIHC is a non-profit 501(c)(3) organization that is responsible for providing Alternative Link with official descriptions of the services and supplies delivered by integrative healthcare practitioners and/or described in ABC Terminology and Code Request Forms. (You may find request forms by visiting www.alternativelink.com/ali/abc_codes/code_request.asp.) FIHC validates these descriptions and requests and then forwards them to Alternative Link. Alternative Link then checks whether complete, accurate and precise older medical codes already exist and reflect the descriptions and/or requests. If no older medical codes have been developed (or if the older medical codes inadequately support scientific research, management and commerce), then Alternative Link assigns an ABC code to more completely, accurately and precisely reflect the area of care.

58. ***How do RVUs get assigned?***
Alternative Link licenses ABC codes to Relative Value Studies, Inc. (RVSI), to develop RVUs for services represented by ABC codes. RVSI conducts surveys of the integrative healthcare practitioner communities to establish RVUs and then licenses the RVUs back to Alternative Link.

59. ***What would be the risk of using integrative healthcare codes that might be developed by the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS) or another coding authority (instead of ABC codes)?***
Older medical codes tend to be less precise than ABC codes and typically lack corresponding RVUs, practitioner modifiers (identifiers), RVUs and legal practice guidelines. Without connecting these data elements, these older medical codes introduce *more* administrative inefficiencies into the healthcare system by making necessary manual checks to ensure the integrative healthcare that is financed, administered and delivered is legal and appropriate. For example, without corresponding practitioner types, RVUs and legal practice guidelines, codes for integrative healthcare would cause otherwise automated processes (such as insurance claims review for compliance with statutes, administrative regulations and case law) to require costly manual checks.

60. ***What will happen if the American Medical Association and/or the Centers for Medicare and Medicaid Services decide to code integrative healthcare anyway?***
If someone else codes integrative healthcare and the industry wants to use those new codes (and if those new codes are sufficiently complete, accurate and precise to support the cost-effective financing, administration and delivery of integrative healthcare), Alternative Link will map or "crosswalk" those new codes to ABC codes, so the new codes can be automatically associated with a practitioner type and linked to the right relative values and legality determinations.

61. ***What is the ultimate goal of establishing ABC codes?***
Alternative Link created ABC codes to improve administrative efficiencies and support the best approaches to care, so more people could gain access to the right care in the right place at the right time, at a rational cost.

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62. *What products and services are available to support the industry's use of ABC codes?*

- ***ABC Terminology and Codes: ASCII Flat File***, a data file that includes ABC codes (5 characters), abbreviated (28 characters) and full descriptions of interventions, loadable into spreadsheets, databases and other applications. **List Price: $49.95 + either $10.00 per seat license or a percentage of revenues (CD-ROM or email delivery).**

- ***ABC Coding Manual for Integrative Healthcare***™, the definitive guide to using ABC codes, that includes the 5-character codes, corresponding descriptions of interventions, and expanded definitions which, in combination, precisely reflect alternative medicine, nursing and other integrative healthcare practices and support research, management and commerce. **List Prices: $79.95 (softcover copy) and $59.95 (CD-ROM).**

- ***Practitioner's Guide to Billable Interventions Using ABC Codes***™, the definitive guide to understanding the legal scope of practice for each of more than a dozen integrative healthcare practitioner types (subject to varying legal requirements from state to state) in each of the 50 United States and the District of Columbia, based on statutes, administrative regulations and case law, and including requirements for licensing, training and supervision. **List Price: $99.95 (softcover copy).**

- ***Superbill for Integrative Healthcare***, an essential tool for integrative healthcare practices, used to assure compliance with legal scopes of practice, and helpful in efficiently documenting and managing patient encounters (by checking applicable boxes next to the codes that represent common diagnoses, as well as services and supplies delivered during patient visits). **List Price: $99.95 for ABC codes, with additional fees for including CPT, HCPCS II and ICD-9 codes, special formatting and logos (print or electronic version).**

- ***HealthIntel Database™***, a complete database of ABC codes, corresponding descriptions, expanded definitions, relative value units, practitioner identifiers and legal logic (on a per intervention, per practitioner and per state basis), especially useful in offering integrative healthcare benefits, in establishing contracts and in adjudicating integrative healthcare claims on the basis of legal scopes of practice. **List Price: $149,950.00 for data sets from all 50 states and the District of Columbia, or $14,950.00 for the first state and $4,950.00 for each additional state, plus fees up to $1.00 per transaction conducted using the database, with negotiable monthly or annual update/access fees depending on transaction volume.**

- ***ABC/HCPCS Crosswalk,*** a tabular publication that maps relationships among the ABC, CPT/HCPCS I and HCPCS II code sets, to help healthcare organizations develop and enhance coding capabilities for integrative healthcare. **List price: $299.95 (softcover or electronic version).**

- ***Relative Values for Integrative Healthcare Using ABC Codes***, the definitive guide to valuing integrative healthcare services, helpful in supporting contracting, pricing and payment decisions, and including ABC codes and corresponding numeric indicators of comparative financial worth, using Relative Value Unit and Resource-Based Relative Value System/Scale methodologies. (Published by Relative Value Studies, Inc., publishers of Relative Values for Physicians, Relative Values for Dentists and Relative Values for Therapists.) **List Price: $197.00 for an ASCII electronic version and a softcover copy or $107.00 for a softcover copy alone.**

- ***Complementary and Alternative Medicine (CAM) Market Report***, highlights of, an overview of, or complete strategic update on, the sociodemographic, economic, political, technological and industrial developments related to the integrative portion of the healthcare market (with ample tables, charts, and appendices to support strategic planning included in the strategic update). (Published by The Foundation for Integrative Healthcare and Mission:Accomplished/Intelliworks, Inc.) **List Price: $195.95 for the CAM Market Highlights, $1,995.00 for the CAM Market Overview and $3,995.00 for the full-length CAM Market Report (softcover copy or electronic version)**.

- ***Consulting Services,*** customized educational programs, research and analytical projects, and management services that help health-promoting organizations and individuals finance, administer and deliver more cost-effective care using ABC codes and coding-related solutions. **List Price: $125.00 to $375.00 per hour.**

- ***Beta Test and Partnering Agreements***, rights to review, evaluate, and guide the development of selected Alternative Link solutions. **List Price: $4,950.00 to $59,950.00.**

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EXHIBIT N – THE NATIONAL FOUNDATION FOR WOMEN LEGISLATORS SUPPORTED ABC CODES IN ITS "ACCESS TO CARE" RESOLUTION

NFWL Access to Care Sub-Committee Resolution
Improving the National Health Information Infrastructure (NHII) and Standards for Health-Related Data

(Introduced August 31, 2003)

WHEREAS, a cost-effective and logical national health information infrastructure is needed to:
1) compile, analyze and disseminate health-advancing information from all health industry stakeholders, including public and private, community, minority and ethnic, and faith-based organizations,
2) provide impartial information on best practices to health, healthcare, and health policy decision makers, and
3) help the greatest number of people exercise their liberties and access the right care in the right place at the right time, at the lowest possible cost;

WHEREAS, the federal government is supporting a public-private collaboration to develop impartial standards for health-related data to:
1) support an optimal information architecture,
2) align financial and other incentives of consumers, caregivers and organizations (e.g., through tax-benefits for achievement of targeted health improvements),
3) enhance health surveillance to support homeland security,
4) support research and population health,
5) enhance safety and quality, and
6) help protect privacy and confidentiality;

WHEREAS, the building blocks of an effective national health information infrastructure are currently incomplete, do not adequately address non-MD/DO/DDS/DMD, non-DDS healthcare professional coding needs and, as a result, may compromise the nation's ability to:
1) identify public health risks (such as bio-terrorism and viral epidemics),
2) avoid individual health risks (such as medical errors and adverse reactions),
3) reverse disparities in health based on income, race and ethnicity,
4) make comparisons of economic and health outcomes of conventional, complementary and alternative approaches to care, and allied health professional care, to identify the best practices available,
5) improve healthcare accessibility, quality and cost-management, and
6) support better health policy decisions;

WHEREAS, the federal government committed to specific improvement in the national health information infrastructure for administrative simplification, including standardization of transactions and code sets under the Health Insurance Portability and Accountability Act of 1996 (HIPAA);

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WHEREAS, the older HIPAA code sets are oriented toward conventional physician and dentist-directed disease-based models of care, and do not provide the practitioner representation, hierarchic coding structure and legal scope of practice information needed to support cost-effective financing, administration and delivery of integrative healthcare;

WHEREAS, HIPAA code sets should be designed, developed and overseen in a manner that facilitates the financing, administration and delivery of the most cost-effective care available;

WHEREAS, complete, accurate and precise clinical and administrative codes are needed to reflect alternative medicine, nursing and other forms of integrative healthcare (including, but not limited to, dental hygiene and other forms of prevention and wellness, as well as impoverished, minority and ethnic, youth, and elderly care);

WHEREAS, incomplete and inadequate standards for health-related data may reduce the effectiveness of the national health information infrastructure and may result in systemic inefficiencies that reduce access to quality care and lead to escalating costs;

BE IT RESOLVED, that the National Foundation for Women Legislator's Access to Care Sub-Committee, under the full Committee of Health & Empowerment, urges the federal government to pass regulations or law to ensure the nation's clinical and administrative codes are developed and managed in an open and impartial manner that supports:

1. scientific assessments of the relative economic and health outcomes of integrative healthcare, as well as complementary and alternative approaches to physician-directed, dentist-directed and other disease-based models of care; and
2. the collection, analysis, and dissemination of health-related data, information and knowledge on all facets of wellness and healthcare to improve individual and public health, business and industry efficiencies, and socioeconomic development;

BE IT FURTHER RESOLVED, that the National Foundation for Women Legislator's Access to Care Sub-Committee, under the full Committee of Health & Empowerment, urges federal and state governments to explore immediate remedies to national health information infrastructure and health-related data challenges, to support the rights of Americans to choose the care that is best for them.

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EXHIBIT O – A REGISTRANT SURVEY INDICATES ABC CODES OFFER A SIGNIFICANT COST-BENEFIT

Perceptions of the Cost-Benefit of ABC Codes in Relation to Public Health, the Healthcare Industry and Stakeholder Interests

Data Collected From www.AlternativeLink.com
Between January 16th and March 16th, 2003

QUESTION

Overall, do you expect ABC codes to offer new benefits and/or contribute favorably to public health? (i.e., the health of individuals)	***Percent***	***Total Responses***
Yes	65.41%	6319
No	1.45%	140
Maybe	13.05%	1261
Not Applicable	0.21%	20
Don't Know	19.88%	1921
Totals	100.00%	9661

Overall, do you expect ABC codes to offer new benefits and/or contribute favorably to the healthcare industry?	***Percent***	***Total Responses***
Yes	67.48%	6446
No	1.11%	106
Maybe	14.17%	1354
Not Applicable	0.09%	9
Don't Know	17.15%	1638
Totals	100.00%	9553

Overall, do you expect ABC codes to offer new benefits and/or contribute favorably to the organization that employs you?	***Percent***	***Total Responses***
Yes	44.26%	4215
No	3.36%	320
Maybe	15.29%	1456
Not Applicable	20.42%	1945
Don't Know	16.67%	1588
Totals	100.00%	9524

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QUESTION

Overall, do you expect ABC codes to offer new benefits and/or contribute favorably to your entire profession?	***Percent***	***Total Responses***
Yes	67.91%	6445
No	1.41%	134
Maybe	16.11%	1529
Not Applicable	0.34%	32
Don't Know	14.23%	1351
Totals	100.00%	9491

Overall, do you expect ABC codes to offer new benefits and/or contribute favorably to you in your job and/or career?	***Percent***	***Total Responses***
Yes	60.77%	5759
No	2.55%	242
Maybe	18.73%	1775
Not Applicable	0.98%	93
Don't Know	16.97%	1608
Totals	100.00%	9477

Overall, do you expect ABC codes to offer new benefits and/or contribute favorably to you (as a consumer)?	***Percent***	***Total Responses***
Yes	59.72%	5652
No	2.87%	272
Maybe	17.00%	1609
Not Applicable	1.60%	151
Don't Know	18.81%	1780
Totals	100.00%	9464

Overall, do you expect ABC codes to create challenges and/or increase costs for public health? (i.e., the health of individuals)	***Percent***	***Total Responses***
Yes	10.04%	956
No	43.71%	4163
Maybe	17.27%	1645
Not Applicable	0.18%	17
Don't Know	28.80%	2743
Totals	100.00%	9524

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QUESTION

Overall, do you expect ABC codes to create challenges and/or increase costs for the healthcare industry?	***Percent***	***Total Responses***
Yes	10.30%	974
No	43.72%	4136
Maybe	18.82%	1780
Not Applicable	0.14%	13
Don't Know	27.03%	2557
Totals	100.00%	9460

Overall, do you expect ABC codes to create challenges and/or increase costs for the organization that employs you?	***Percent***	***Total Responses***
Yes	7.63%	721
No	39.72%	3754
Maybe	14.08%	1331
Not Applicable	18.53%	1751
Don't Know	20.04%	1894
Totals	100.00%	9451

Overall, do you expect ABC codes to create challenges and/or increase costs for your entire profession?	***Percent***	***Total Responses***
Yes	9.35%	882
No	45.55%	4297
Maybe	19.11%	1803
Not Applicable	0.36%	34
Don't Know	25.63%	2418
Totals	100.00%	9434

Overall, do you expect ABC codes to create challenges and/or increase costs for you in your job and/or career?	***Percent***	***Total Responses***
Yes	9.64%	911
No	46.41%	4384
Maybe	19.16%	1810
Not Applicable	0.66%	62
Don't Know	24.13%	2279
Totals	100.00%	9446

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QUESTION

Overall, do you expect ABC codes to create challenges and/or increase costs for you (as a consumer)?	***Percent***	***Total Responses***
Yes	6.15%	582
No	51.62%	4882
Maybe	15.44%	1460
Not Applicable	1.25%	118
Don't Know	25.54%	2416
Totals	100.00%	9458

When do you plan to use ABC codes?	***Percent***	***Total Responses***
Currently in Use	2.21%	213
This Month	14.13%	1364
3 to 6 Months	24.34%	2349
6 to 12 Months	9.02%	871
12 to 24 Months	4.21%	406
Beyond 24 Months	1.22%	118
Don't Know	44.09%	4256
Not Applicable	0.78%	75
Totals	100.00%	9652

Do you need help ensuring all your trading partners, business associates and vendors have registered as well?	***Percent***	***Total Responses***
Yes	20.00%	1556
No	42.64%	3317
Maybe	10.91%	849
Not Applicable	7.04%	548
Don't Know	19.40%	1509
Totals	100.00%	7779

May we contact you to learn more about your perspectives on these issues?	***Percent***	***Total Responses***
Yes	67.04%	4952
No	32.96%	2435
Totals	100.00%	7387

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EXHIBIT P – WEB SITE INSTRUCTIONS SUPPORT USER TRAINING

How ABC Codes Are Being Rolled Out Across the Industry
Excerpt from the Alternative Link Web Site (www.AlternativeLink.com)

"*Are ABC Codes HIPAA Compliant?*

Yes. ABC codes may be used by anyone for research management and manual commerce, and the codes are also HIPAA-compliant when used in electronic commerce by registered users and their contractual trading partners.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was designed, in part, to simplify administrative processes in healthcare. It gave the Secretary of HHS the authority to permit exceptions from older HIPAA transaction and code set standards to evaluate proposed modifications to those standards.

ABC codes are a proposed modification that identifies alternative medicine, nursing and other integrative healthcare interventions. These interventions are not adequately described by the American Medical Association's Current Procedural Terminology (known as CPT or HCPCS Level I codes) or a key section of the Centers for Medicare and Medicaid Services' Healthcare Common Procedure Coding System (known as HCPCS Level II codes) or the American Dental Association's Code on Dental Procedures and Nomenclature (known as CDT).

To respond to gaps in the HIPAA code sets and to accelerate the ABC code set review process, the Secretary authorized commercial use and cost-benefit evaluation of ABC codes under 45 CFR 162.940, a special section of the HIPAA regulations.

HHS authorized use of ABC codes in HIPAA transactions in conjunction with CPT and HCPCS Level II codes for at least two years. During that time, HHS will secure data on the cost-benefit of ABC codes in HIPAA transactions. This will help HHS complete its code set evaluation and HIPAA standard-setting process.

Again, ABC codes are HIPAA compliant when used by official code set registrants and their contracted trading partners. (ABC codes may be used by anyone for research management and manual commerce, since these uses are unregulated.)

How Are ABC Codes Being Commercialized?

Implementing a new code set on a national scale poses some interesting challenges. For example, some health plans may hesitate to recognize ABC codes until the codes are broadly used by practitioners, and some practitioners may hesitate to use ABC codes until the codes are broadly recognized by health plans. Individuals and organizations want to know their time and resource investments will pay off, and these contradictory conditions can create some uncertainties.
We are overcoming this "Catch 22" in three steps. First, we are working with you and others in the industry to ensure all covered entities, trading partners, business associates and vendors affected by

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HIPAA have secured their rights to use ABC codes in HIPAA transactions.

Second, we are working with you and others to design business processes that will ensure you benefit significantly from code set use.

Third, we are helping you and others implement these business processes to achieve your desired outcomes.

We are targeting business processes where bottom line improvements can quickly be realized, e.g., health insurance benefits plan design, managed care and provider contracting, utilization and clinical practice management, claims processing, outcomes research and actuarial analyses. In the process, we are uncovering other applications of the code set that will deliver value to end-users like you.

With many business processes and implementation plans already developed, we are rolling out the codes across "value chains"—that is, among groupings of covered entities, trading partners, business associates and vendors that do business together. For example, we have already begun work with 1) leading employers, health plans, clearinghouses and their participating providers and 2) a consortium of academic research centers, a centralized data warehousing site and various integrative healthcare research teams.

In helping these industry stakeholders with code set implementation, we are ensuring the codes facilitate comparisons of the economic and health outcomes of conventional, complementary and alternative care. This is giving health policymakers a more complete and accurate picture of the financing, administration and delivery of integrative healthcare products and services.

What Happens Next?

The introduction of a new code set as a proposed modification to the HIPAA standards is unprecedented. It is expected to have profound effects on the advancement of individual and public health, business and industry efficiencies and socioeconomic development.

We will keep you informed as we begin to roll out the codes across the various value chains. We welcome your input as we clarify the needs of each category of individuals and organizations to move forward in this beneficial undertaking."

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EXHIBIT Q –ABC CODES CAN HELP STABILIZE U.S. HEALTHCARE

The U.S. Healthcare Crisis

Because of cost-escalation, individuals, private sector organizations and government purchasers are increasingly challenged to afford healthcare. This has devastating implications for the health of Americans and the U.S. economy.

For the last two decades, the rate of medical inflation has averaged twice that of general inflation. In the last two years, health insurance premiums have grown more than five times the rate of general inflation.[338]

Employers cover about 120 million people and are the primary source of health insurance in the U.S.. Government purchasers also cover a large number of Americans. As employers, Federal, State and Local governments (including the military) cover about 39 million lives. In addition, the major public insurance programs (Medicare and Medicaid) cover some 39 million and 41 million lives, respectively.[339]

U.S. employers who voluntarily sponsor health insurance coverage, risk their bottom lines and financial viability. (They are already challenged with an economic downturn, worker's compensation liabilities and increasing risks of litigation.) In this context, escalating premiums are increasingly difficult to justify economically. Naturally, a growing number of employers are choosing to drop health benefits entirely or transfer additional costs to employees.

The newly uninsured are associated with organizations of all sizes and tend to represent 1) employees and dependents in small companies that used to offer coverage but have chosen to drop it, and 2) employees and dependents in companies that are maintaining coverage while increasing the employee contribution to premium, especially for dependents.[340]

As employers withdraw or reduce job-based health benefits, the financial burden of healthcare on individuals and the public sector further escalates. According to the Center for Practical Health Reform, a 1% annual decrease in the number of Americans with employer-sponsored coverage translates to a 4% annual increase in the number of uninsured.

The U.S. Census Bureau reported the number of uninsured increased 2.4 million in 2002 (about a 6% increase over 2001), and the total number of uninsured reached 43.6 million.[341] About 34 million more had inadequate insurance.[342] Uninsured and underinsured Americans are susceptible to financially devastating healthcare crises. The inability to pay healthcare bills contributes to about half of personal bankruptcies in this country.[343]

Privately-funded health benefits account for about 55% of total healthcare funding. Reductions in employer-sponsored coverage result in reduced revenues for health industry businesses and reverberations through the larger U.S. economy.

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For example, a 5% drop in enrollment translates to about a 2.5% drop in total healthcare funding. Since healthcare represents about 15% of the Gross Domestic Product, $1 in every $7 spent, and 1 job in every 11, drops in total healthcare funding result in drops in demand for consumer goods, energy and nearly all other commodities.[344] Slowdowns in demand accelerate the economic downturn, particularly as publicly trading companies with high revenue sensitivities, see drops in profit, share price, market capitalization and credit. [345]

Three Causes of the Crisis

Cost-escalation results in large part from
1. an inability to determine what does and does not work and at what cost,
2. unintended consequences of subsidized health insurance benefits, and
3. an industry so fragmented that it is easily controlled by special interests.[346]

Few health industry organizations can exchange information in a manner that ensures the right care is delivered in the right place at the right time, at a rational cost. In the absence of objective data and effective mechanisms for data-sharing, decisions on the financing, administration and delivery of care tend to be based on supposition. This results in substandard care, misallocation of resources (including both over- and under-utilization of healthcare products and services), administrative waste, and a lack of accountability for the economic and health outcomes of care. [347]

Subsidized health insurance benefits shelter consumers from the significant financial effects of unhealthy lifestyles and from making value-driven choices about healthcare.[348] This leads to risky lifestyle choices and escalating demand for acute care and, later in life, chronic care—without regard to cost ramifications or evidence of relative effectiveness.

In the absence of data-sharing and accountability for outcomes, the fragmented health industry is subject to special interest influence.[349] For example, basing payment for services on usual, customary and reasonable charges (UCRs) rather than on financial and clinical outcomes of care rewards caregivers who increase charges over time and reduce resources dedicated to care delivery. Basing payment for services on resource-based relative values rewards certain categories of practitioners who may be less cost-effective than other categories. Basing payment for products on average wholesale prices (AWPs) rewards manufacturers who either misrepresent AWPs to give practitioners margins for channeling products or continually raise their AWPs.

The lack of health-related data and communication standards, the limited accountability for economic and health outcomes of care, and the proliferation of special interest behaviors creates distrust.[350] This distrust exacerbates the challenges by leading to an unwillingness to share data and otherwise communicate, a fear of revealing the relative outcomes of care, and an interest in maximizing short-term gains lest a perceived adversary somehow secure an upper hand over time.

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ABC Codes as a Key Solution

A reasonable starting point for resolving the U.S. healthcare crisis is the development of

4. complete, accurate, precise, open and impartial health-related data standards,

5. shared communication protocols, and

6. universally compatible information technology platforms.

These targeted advances in the NHII could help a broad variety of health industry stakeholders more easily identify and communicate what works, what does not work and at what cost—an essential step in resolving the other two causes of the U.S. healthcare crisis.

ABC codes reflect the vocabularies and professional training of more than 3 million licensed healthcare practitioners whose practices are not adequately reflected in the HIPAA code sets:

- Acupuncturists
- Certified Midwives
- Certified Nurse Specialists
- Chiropractors
- Holistic Physicians
- Massage Therapists
- Mental Health Specialists
- Osteopaths
- Naturopathic Doctors
- Nurse Midwives
- Nurse Practitioners
- Physical Therapists
- Physician Assistants
- Registered Nurses
- Vocational Nurses

ABC codes are backed by a database of relative value scores (RVU/RBRVS data) developed by **Relative Value Studies, Inc.**, as well as legal scope of practice information derived from statutes, administrative regulations and case law in all fifty states and the District of Columbia. This information ensures the financial value and legality of care can be determined automatically, on a per intervention, per practitioner and per state basis. No other code set supports such automated claims review/adjudication.[351]

In addition to reflecting the practices of more than three-quarters of the nation's caregivers, ABC codes now represents about 1.4 billion episodes of care annually—more than the annual number of visits made to all categories of conventional allopathic physicians.[352]

In contrast, medical and dental codes are not assigned payable codes unless the corresponding care meets prevalence, philosophical compliance and budgetary considerations of trade associations and government payors.

For example, according the American Medical Association's web site, "the inclusion of a descriptor and its associated specific five-digit identifying code number in…(the payable) category of CPT codes is generally based upon the procedure being consistent with contemporary medical practice and being performed by many physicians in clinical practice in multiple locations."[353]

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While another category of codes can be assigned without meeting these criteria, to facilitate data collection and technology assessment, these "emerging technology" codes are denied assignment of relative values[354] (necessary for inclusion in electronic commerce) and classified as experimental or investigational (a designation that drives exclusion of care from coverage and reimbursement).

Similarly, the American Dental Association's Current Dental Terminology (CDT) and Code on Dental Procedures and Nomenclature "is periodically reviewed and revised to reflect the dynamic changes in dental procedures that are recognized by organized dentistry and the dental community as a whole…Requested changes to the Code on Dental Procedures and Nomenclature are evaluated and voted upon by the Code Revision Committee (CRC), a body that has equal voting representation from members of the profession and members of the third-party payer community. Requests for addition, revision or deletion…are… evaluated by the CRC using additional criteria that include…(whether)… the procedure currently taught in an accredited dental school, or in an accredited post-graduate program (and) is… currently accepted dental therapy…The goal…would be a code set that includes only those procedures needed to adequately maintain patient records and to support dental claim submission.[355]
This dental code set does adequately reflect the care of dental hygienists (a professional group that has consequently asked Alternative Link to develop ABC codes for dental hygiene).

The federal government's Healthcare Common Procedure Coding System code application notes that "all products must have 6 months of marketing experience prior to submitting a request for coding consideration and following FDA approval for marketing…(and) the item/product primarily and customarily used to serve a medical purpose." It also calls for prevalence reporting and focuses on conventional approaches to care (e.g., drugs, biologics, devices) delivered in conventional medical settings. [356]

The implications of prevalence, philosophical compliance and budgetary considerations in coding are concerning, as a simple analogy from the grocery industry illustrates.

In this industry, an American Food Association could withhold or manipulate bar codes on international foods if it (rather than a Uniform Code Council) had authority over Universal Product Codes. This would give American food suppliers the ability to limit competition and increase prices for American foods. By withholding or manipulating coding for international foods, they could force international food suppliers and their customers to depend on manual forecasting, distribution and purchasing systems. This would result in a highly inefficient "supply chain" that would lead grocers to view stocking of international foods as cost-prohibitive.

In the health industry, trade associations actually do have authority to withhold or manipulate codes that represent care delivered by competing practitioner types. This control over coding of competing interventions offers these associations cartel-like and monopolistic powers. In the absence of complete, accurate and precise codes for their professions, disenfranchised healthcare practitioners cannot compete for managed care contracts.

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This artificially reduces the volume of services competing for each available dollar—a classic outcome of cartel behavior. Further, inadequate coding ensures that relative values—the basis for payment—either cannot be assigned or will not reflect the true value of delivered care.

This blocks the care that lacks relative value unit assignments from purchasing consideration and direct reimbursement (e.g., for advanced practice nursing), further reducing competitive service volume and further supporting price increases for the types of care supported by the coding authorities.

The challenges of special interests affecting coding are not unique to the private sector. In the public sector, government-sponsored programs are two steps from incurring budget impact as a result of a new healthcare product or service: 1) consideration of code issuance and, if issued, 2) establishment of favorable or unfavorable coverage policies and, if favorable, 3) establishment of payment levels. Avoiding code development keeps the prospects of payment and adverse budget impact remote. The resulting lack of codes for unbudgeted interventions can prevent Americans reliant on government-subsidized care from getting care they need—care that might ultimately save government payors money by displacing or cost-effectively complementing older approaches to care.

ABC codes are different in that they reflect the vocabularies and practices of the integrative healthcare communities without bias. Developed in an open and impartial manner, ABC codes meet the recommendations of the 2003 NHII Standards and Vocabulary Track (described below) and overcome "Commonly Cited Flaws of ICD-9-CM and CPT-4 Procedure Classification Systems"[357] noted in a November 1993 NCVHS advisory report to the HHS Secretary. The terminology from which ABC codes originate (and/or the ABC codes themselves) can be licensed or mapped (crosswalked) to any coding system preferred by HHS (such as ICD-10-PCS).

In the meantime, ABC codes fill critical gaps in older coding systems and the NHII so that all approaches to healthcare can be objectively tracked, analyzed and managed. This is essential for more than just administrative simplification in research, management and commerce. It is essential for the advancement of evidence-based care.

For example, used in conjunction with older code sets, ABC codes support comparisons of the economic and health outcomes of conventional, complementary and alternative care. In doing so, the codes help identify best practices. This gives health industry decision-makers critical insight about the cost-effectiveness of potentially competing approaches to care—insight that can serve as a basis for better case management, coverage and reimbursement policies.

In an era of limited resources and relatively unlimited demand, knowing what interventions work best and cost least is essential to getting a greater number of Americans the care they need.

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EXHIBIT R – ABC CODES SUPPORT NHII ENDPOINTS

> ***"One of the ways the NHII could be strengthened is through more rapid adoption of and compliance with existing standards and accelerated development of other needed standards."*** – NCVHS, Information for Health.

A fully-evolved national health information infrastructure (NHII) would improve the quality of care, support public health surveillance, and enhance the efficiency of the U.S. healthcare system.[358] ABC codes are increasingly viewed as an essential health-related data standard[359] and could serve as a veritable "poster child" for the public-private collaborations viewed as necessary to facilitate advances in the NHII. They are urgently needed 1) to ensure the 1.4 billion patient encounters with integrative healthcare practitioners are not lost to those commissioned with securing early warnings of bioterrorism and other health threats and 2) to support the adoption of best practices across the nation.

In a third quarter conference, "National Health Information Infrastructure 2003: Developing a National Action Agenda for NHII,"[360] HHS invited a broad base of health information technology stakeholders to develop a consensus for national action in eight key areas:

1. Research and Population Health
2. Homeland Security
3. Consumer Health
4. Financial Incentives
5. Safety and Quality
6. Standards and Vocabulary
7. Architecture
8. Privacy and Confidentiality

The Standards and Vocabulary Track focused on how to promote development, ongoing maintenance, and widespread use of health-related data content and transmission standards. The track committed to look beyond the HIPAA administrative standards and focus on additional data standardization to support clinical care, public health and research.[361]

The track opened with discussion of the ideal goal/state: [362]

> "Health-related data would be collected once and then used for all appropriate health-related functions. Public health surveillance would occur automatically as a by-product of healthcare. Statistical and billing data would be generated automatically from clinical data. Clinical data collected at different locations would be aggregated for research and other purposes. Data would be geo-coded at the point of capture. Standardization would facilitate decision support, aggregate and trend analyses, and comparison between institutions and geographic areas.

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> Because the same standards are required by different Federal, state, and local agencies, costly duplicate data collection and translation would be avoided.
>
> A robust information model would describe the entities that collect or use health data and the relationships among them, thus defining the universe that requires standardization. Standard document architectures, messaging formats, algorithms, guidelines, and vocabularies would reflect the information model and be interlocking, e.g., a standard vocabulary or a set of standard allowed values would be established for every data element or message field that requires one.
>
> Data element, messaging, vocabulary, and identifier standards would address all the contexts in which health data were collected and used, ***reflecting the data needs of all types of healthcare professionals, the public health workforce, patients, and the general public and of the full range of organizations that create or use health data.***
>
> ***The organizations responsible for the maintenance and quality of specific health data standards would coordinate their activities to avoid duplicate or conflicting standards and provide a single point of entry for requests for changes and additions. Standards would be maintained and their quality assessed through an open process that is responsive to the health data needs of the full range of stakeholders.***
>
> If and when the federal government or private foundations funded the development of health vocabularies, these efforts would be designed to complement, extend, or improve existing standards and not to duplicate or compete with them."

ABC codes were discussed at length in this track by advocates of alternative medicine, nursing, holistic medicine, health surveillance and scientific data collection. In light of this discussion, track leadership recommended in its "action agenda" that open and unbiased administrative and clinical code sets (like ABC codes) be supported to track, analyze and better manage care delivered by all healthcare practitioner types across the healthcare continuum. This recommendation was disseminated to guide the further development of NHII by both the Federal government and the private sector.[363]

This July, Alternative Link participated in the Second Annual Conference on the NHII to further advance reliance on open and unbiased administrative and clinical codes, such as ABC codes.

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EXHIBIT S – ABC CODES MEET DSMO, NCVHS, CMS AND HHS REQUIREMENTS FOR HIPAA STANDARDS

(*Note: ABC codes used to be referred to as "ABCcodes."*)

'90	Conceived of the need for standard fee structures for alternative medicine interventions based on founder's experience using codes when developing managed care contracts.
'93	Recognized flaws in AMA coding development process as NCVHS criticized AMA for not including non-MD provider services and stated that AMA may have bias in favor of conventional physicians.
12/ 95	Identified state and national insurance models of reimbursement for alternative medicine in the US and found that most models were based on in-house coding schemes.
04/ 96	Found that state scope-of-practice laws varied widely, a major deterrent to filing claims within Fraud and Abuse legislation.
05/96	Reviewed CPT codes to determine which alternative medicine procedures or services were available for managing care, claims and outcomes for alternative medicine services. Found no codes in the AMA's Current Procedural Terminology (CPT) coding manual specific to alternative medicine. Coordinated with Dr. Theodore Rozema to contact AMA and asked for specific alternative medicine codes. Learned that the CPT contact told Dr. Rozema that codes would not be developed for alternative medicine.
06/96	Conducted a national and international patent search to determine if procedure codes for alternative medicine had been paired with state scope of practice laws in a database to facilitate the creation of business rules to support administrative transactions for alternative medicine services and supplies.
07/96	Discovered that the 1996 Federation of State Medical Boards Annual Meeting centered on a campaign against alternative medicine practitioners (referred to throughout the meeting as "quacks").
08/96	Reviewed the Health Insurance Portability and Accountability Act (HIPAA) to master the rationale and process for the development of electronic standards.
09/96	Filed a patent application to develop codes and insurance claim-editing capabilities that would allow licensed alternative medicine practitioners to file claims within state scope of practice laws, avoid fraudulent billing practices, and reduce paperwork burdens and billing errors caused by manual processes.
10/96	Reviewed code request surveys provided by Dr. Rozema, a board member of the American College for the Advancement of Medicine, from thought- and practice-leading academic programs: Bastyr University Natural Health Clinic, Emperor's College of Traditional Oriental Medicine, Logan College of Chiropractic, Minnesota Institute of Acupuncture and Herbal Studies, National College of Chiropractic, National College of Naturopathic Medicine, Traditional Acupuncture Institute, Inc., Traditional Chinese Medicine Clinic, Western States Chiropractic College
12/96	Developed and validated a standard operating procedure to create billing terms (830 concepts) for acupuncture, chiropractic, massage and bodywork.
01/97	Learned that AMA had published only four codes for chiropractic services.
05/97	In accordance with a validated standard operating procedure, sought input from acupuncture, chiropractic, midwifery, massage therapy and naturopathic schools, credentialing bodies, state licensing boards and national experts to help develop a comprehensive set of alternative medicine codes.
06/97	Contracted with the retired claims manager from American Western Life to understand how that company processed claims from alternative medicine providers in ten states. Found that they had developed in-house coding and that these codes were assigned relative value units (RVUs).
07/97	Called all congressional delegates from New Mexico to find appropriate government agencies and standards development organizations to promulgate an alternative medicine code set through the Department of Health and Human Services in order to help create a standard for administrative transactions under HIPAA.
07/97	Corresponded with HCFA regarding intent to develop alternative medicine codes.
08/97	Sent first set of 830 coded alternative medicine terms to the National Institutes of Health/National Library of Medicine (NLM).
09/97	Met with NLM staff. Received guidance on specific changes in the structure of ABC codes, e.g., use of a hierarchy and unique code identifiers, to assure that ABC codes met congressional intent under HIPAA and met or exceeded internal structural requirements of other code sets.
10/97	Implemented changes proposed by NLM and re-submitted the code set and terminology to NLM.
10/97	Sent ABC code information to the National Uniform Claims Committee, the American National Standards Institute's (ANSI's) American Standards Committee X12N, the American Dental Association, the Health Care Financing Administration (HCFA, now the Centers for Medicare and Medicaid Services or CMS) and Health Level 7. Notified them of the development of a new potential HIPAA code set.
11/97	Received an endorsement letter from the New Mexico Chiropractic Association.

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11/97 Reviewed the ICD-10PCS system to understand its structure and to determine if this proposed new code set, under development by 3M through a contract with HCFA, would work for alternative medicine administrative transactions. Polled organizations in the healthcare industry to determine if they would adopt ICD-10-PCS. Was told that the cost of adopting this code set was prohibitive and its content did not meet the data needs of payors vis-à-vis reimbursement schemes. Continued with ABC code set development and management.

11/97 Polled health insurance software vendors to determine their design integration requirements for administrative code sets.

11/97 Attended a CPRI Conference on Terminology in Washington, DC, and heard a Director of the HCFA Systems Group explain structural and developmental problems associated with existing code sets.

12/97 Sent ABC codes to the National Committee for Health Statistics for review and guidance.

12/97 Received request from National Library of Medicine to include ABC codes in Unified Medical Language System (UMLS).

12/97 Requested a license from the AMA to crosswalk ABC codes to CPT codes to determine which CPT codes alternative providers were using and if they were following state scope of practice laws.

12/97 Licensed ABC codes to Sloans Lake MCO of Colorado for beta testing of the original ABC code structure. Received a suggestion from Sloans Lake that ABC codes be changed from 7 characters to 5 characters. This request echoed recommendations from payers and software vendors.

01/98 Learned that the AMA had published only two codes for acupuncture. Was advised by acupuncture and coding experts that these codes were so generic that no relative value could be developed for them. Recognized that these codes did not meet congressional intent under HIPAA because they did not convey information needed for reimbursement.

01/98 Completed and forwarded to the AMA a complete licensing application for a crosswalk from ABC codes to CPT codes.

02/98 Sent electronic files containing ABC codes to NLM for publication in the UMLS.

02/98 Contacted HCFA to ensure that an all alphabetic code structure would support government code set objectives and would be compatible with existing HCPCS code sets.

02/98 Resubmitted the restructured (5 versus 7 character) ABC codes to NLM/UMLS.

03/98 Redelivered the ABC code set database to Sloans Lake MCO with the 5-character, all alphabetic code structure. Heard back from Sloans Lake that ABC codes loaded easily into their claims management software.

03/98 Licensed ABC codes to Relative Value Studies, Inc., to publish RVUs for ABC codes.

04/98 Licensed the ABC codes and legal scope of practice database to Health and Healing Trust of NJ, PA, and NY.

05/98 Attended an HL7 meeting and met with the Vocabulary Special Interest Group. Learned that clinical coding needs differed from insurance payer claims processing needs. Concluded that the hospital industry and the insurance industry lacked understanding of each other's coding needs.

05/98 Noted that the Notice of Proposed Rule Making (NPRM) identified potential national code sets. Confirmed that HIPAA prohibited development of local codes and required the Department of Health and Human Services to identify national coding schemes to support healthcare claims by all licensed providers. Confirmed the code set gap for alternative medicine practitioners and payers that offered complementary and alternative medicine benefits.

05/98 Attempted to pay additional licensing fees to the AMA for the annual CPT crosswalk. Found that the CPT license department had cashed Alternative Link's licensing application fee but had withheld the licensing agreement, despite Alternative Link's January 1998 submission of a complete license application. Received an accusation from the AMA that Alternative Link was in violation of the AMA's licensing agreement. Responded with the help of an attorney and provided evidence of the license application and canceled check.

06/98 Commented on NPRM and provided over 50 pages of evidence that ABC codes met the 10 guiding principals required by HIPAA for code set development.

06/98 Received minor NLM/UMLS suggestions for changes to ABC code content. Resubmitted changes and sent newly-developed expanded definitions for each procedural ABC code to support UMLS concepts for alternative medicine and nursing.

07/98 Signed agreement with Nursing Intervention Classification (NIC) developers and modified NIC terminology to meet insurance claims and outcomes measurement requirements as described by HIPAA. Created new ABC codes from NIC terminology based on this information

09/98 Added 800 nursing terms to ABC code database including procedures developed from HHCC and OMAHA Nursing Terminologies

09/98 Received the delayed AMA/CPT license to crosswalk ABC codes to CPT codes. Noted that the application annual licensing fee was sent to the AMA nine months earlier.

10/98 Signed an agreement with Integrative Medicine Communications for a coding manual based on ABC codes.

12/98 Signed an agreement with EDI-USA to use ABC codes in EDI transactions.

03/99 Directed publisher (IMC) to AMA licensing department when publisher desired to publish a crosswalk to CPT codes in forthcoming coding manual publication.

04/99 Received notice from IMC that the AMA had granted a fair-use (free) license for a crosswalk to CPT codes in forthcoming coding manual.

04/99 Signed an agreement with Relative Value Studies, Inc., to create and publish RVUs for ABC codes.

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05/99 Received an invitation to testify before the NCVHS Subcommittee on Transactions and Code Sets and learned that NCVHS was hearing testimony about gaps in proposed national standard code sets.

06/99 Notified the AMA of Alternative Link's US patent for a claims edit/scrub rules engine and process.

09/99 Received "cease and desist" letter from the AMA pertaining to coding manual developed by IMC.

10/99-03/00 Began legal discussions with the AMA. Explained to AMA lawyers that IMC was granted a license for publishing CPT codes crosswalked to ABC codes and that the "cease and desist" letter to Alternative Link was inappropriate. Offered in writing to work cooperatively with the AMA, again. Was told that the AMA declined. Determined that continuing with AMA licensing agreements for CPT crosswalks enabled the AMA to disrupt Alternative Link business with frivolous accusations and was legally burdensome. Retired all ABC codes that crosswalked to CPT. Determined that fewer than 10% of codes that remained in the ABC code set had any relationship to CPT codes.

04/00 Received unanimous support from the ANSI Accredited Standards Committee X12N to include ABC codes in version 04022 of this electronic standard for health insurance claims, a requirement for being named a HIPAA standard code set.

05/00 Learned that ABC codes were listed (in a government publication on national standards) as a potential HIPAA code set for administrative transactions, prior to the Final Rule for Code Sets and Transactions. Noted that ABC codes were categorized in the same manner as the AMA's CPT codes.

06/00 Received information from HHS that, although ABC codes would not be named in the initial Final Rule, a process would be published which could allow ABC codes to be included in future updates to version 004010 of the ANSI ASC X12N standard.

08/00 Received a letter from the Chair of the American Bar Association Committee on Complementary and Alternative Medicine stating that ABC codes met numerous standards initiatives, including international standards requirements.

08/00 Added ABC codes to the claims administration system of Brokerage Services, Inc., a third party administrator now owned by Safeco. Received notice that BSI was processing alternative medicine services used in a Medicare product developed by St. Joseph's HMO in New Mexico.

09/00 Began negotiations for "CAM and Nursing Coding Manual" and "State Legal Guide to CAM and Nursing" publishing contracts with Thomson/Delmar Learning.

09/00 Received letter of intent from PricewaterhouseCoopers for strategic alliance.

09/00 Learned that HCFA incorrectly believed ABC codes were state specific and therefore might not qualify as a national HIPAA standard.

10/00 Sent 50 coding manuals to NCVHS committee members and standards experts to help the government and standards organizations understand that ABC codes were not state specific. Clarified that code reports were available in a database maintained by Alternative Link that listed which ABC codes were allowed for each practitioner in each state according to statutes, administrative regulation and/or case law.

10/00 Received official American Nurses Association recognition of ABC codes and accompanying terminology.

11/00 Received a copy of a letter from Dr. Joel Orona of Arbor University requesting that the Secretary of HHS adopt ABC codes to track the outcomes of Native American tribal medicine.

12/00 Received official American Preventive Medical Association (now called the American Association for Health Freedom) recognition of ABC codes.

01/01 Requested that the Designated Standard Maintenance Organizations (DSMOs) add ABC codes to the HIPAA standard. Contacted CMS coding expert for Medicaid agencies and asked if ABC codes needed any modifications to work with HCPCS codes. Received recommendation that the modifiers to ABC code change from two alpha characters to one numeric and one alpha character to avoid confusion with Medicaid code modifiers.

01/01 Received letters from the Associated Bodywork and Massage Professionals, the Midwives of North America, the California College of Midwives, and Citizens for Midwifery in support of ABC codes.

01/01 Announced partnership with Thomson/Delmar Learning for publication of coding manual and state legal guides. Implemented ABC code modifier changes requested by CMS coding expert.

03/01 Received endorsement of ABC codes by the Oriental Medicine Association of New Mexico.

04/01 Received a copy of a letter to the DSMOs from the Acupuncture Association of Washington supporting inclusion of ABC codes as a HIPAA standard.

05/01 Received letters of intent to use ABC codes from American Healthcare Alliance (with PPO affiliates that cover 23 million lives), Preferred Health Systems (an HMO, PPO and TPA) and Via Christi Hospitals. Learned of Preferred Health Systems' challenge to meet alternative medicine related demands from unions at Boeing, Raytheon, Leer and Cessna.

05/01 Received a copy of a letter to the Secretary of HHS from the President of the Acupuncture Association of Rhode Island, the Vice President of the Foundation for the Development of Integrative Medicine and a Board Member of the American Association of Oriental Medicine supporting adoption of ABC codes as a HIPAA standard.

06/01 Announced a partnership with Mitchell Medical, developers of web-based application service provider (ASP) medical review systems and software licensed to the majority of automobile insurance companies to edit medical claims that result from auto accidents.

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06/01 Received notice that the Florida State Oriental Medical Association wrote to the Secretary of HHS requesting ABC codes be named a HIPAA standard. Received copy of a letter to the Secretary of HHS from Leland Kaiser, Ph.D., President of the Kaiser Institute, requesting that ABC codes be named a HIPAA standard. Received copy of a letter from Russ Greenfield, MD, medical director of Carolinas Integrative Health to HHS stating that ABC codes were being used in his clinic and were "exquisitely detailed," and were needed for outcomes measurements and "to determine both cost and therapeutic effectiveness of alternative therapies…"

08/01 Received copy of a letter to the DSMOs from the Nursing Intervention Classification (NIC) system developers in support of naming ABC codes a HIPAA standard.

08/01 Received "request denied" status from DSMOs and learned that 1) the DSMOs were not convinced that Alternative Link had proven that ABC codes were used by payers, providers and the healthcare industry; and that 2) Alternative Link should explain why HIPAA standard code sets did not meet the needs of the industry.

08/01 Appealed the DSMO decision. Provided further written evidence that the ABC codes were recognized by payors, providers and the healthcare industry. Explained industry sensitivity to HIPAA compliance pressures and explained that the code set would be broadly and promptly used if the HHS gave an indication that the functionality provided by ABC codes would be supported as a HIPAA standard. Was told by the DSMOs that the appeal was denied and that Alternative Link must go through the DSMO request process again. Received no official rationale for the denial. Incurred an additional five-month delay by the DSMOs which made impossible the inclusion of ABC codes in the NPRM process to support their inclusion in transaction and code set implementation requirements for October of 2003.

10/01 Submitted the second DSMO request with letters from clients and national associations. Reported (again) to the DSMOs that the AMA permanently chaired the National Uniform Claims Committee and sat on the National Uniform Billing Committee. Asked that the AMA refrain from voting on Alternative Link's second DSMO request.

10/01 Received American Nurses Association support of ABC codes as independent code set for HIPAA transactions.

10/01 Received a copy of a letter from Senator Pete Domenici, NM, to Secretary of DHHS in support of Alternative Link's proposal to be a named HIPAA standard.

01/02 Was invited to testify to the NCVHS.

01/02 Learned from the NCVHS that the testimony was postponed.

02/02 Learned from the DSMO chairperson that the government's 90-day response deadline would be extended (and the potential for ABCcoding's potential inclusion in the next NPRM would therefore be minimized). Researched the DSMO website to determine whether any DSMO directives remained unaddressed and found no remaining directives. Contacted the DSMO chairperson and asked for a DSMO explanation or response. Was told by the Chairperson that the response would be delayed for an additional 15 days.

03/07/02 Met with Stanley Nachimson of CMS at a Self-Insured Institute of American conference and was told that DSMOs had decided that Alternative Link must go back to CMS and the AMA to ask again for inclusion of ABC codes into these code sets.

03/13/02 Received an email from Kaye Riley, Director of HCPCS codes at CMS, conveying that ABC codes should be an independent standard HIPAA code set and that the ABC codes, because of their structure, would not fit into HCPCS.

03/13/02 Left a voice-mail message for Michael Beebe, Director of CPT Editorial Process, to comply with Stanley Nachimson's directions to go back to the AMA and request integration of ABC codes and CPT codes.

03/16/02 Attended "HIPAA Conference West" and was publicly admonished by the DSMO chairperson for not following the DSMOs request that Alternative Link seek codes from the AMA. Lost a potentially lucrative health plan supporter who now believed that Alternative Link was not following government processes.

03/19/02 Spoke with Michael Beebe about the HHS directive to try to integrate ABC codes and CPT codes. Asked 1) how the AMA and Alternative Link could jointly ensure code review is timely, so that coding would be quickly available for health services research, tracking and payment of services currently being rendered, and actuarial analyses by payers and others; 2) how the AMA and Alternative Link could jointly and efficiently categorize, assess and incorporate the estimated four thousand service and supply codes Alternative Link had already researched and validated; 3) how the AMA and Alternative Link could jointly address the variability in state licensing requirements and scope of practice laws that affect non-MD interventions; 4) how the AMA and Alternative Link could jointly ensure that the code review process did not subject non-MDs and coding to allopathic physician biases when the CPT® Editorial Panel was dominated by conventional practitioners and the coding application instructions included wording such as, "The inclusion of…(Category I)…codes is generally based upon the procedure being consistent with contemporary medical practice and being performed by many physicians in clinical practice in multiple locations;" and 5) how the AMA and Alternative Link could jointly ensure Alternative Link's intellectual property was protected when the code application requires Alternative Link to prospectively "assign to the AMA all rights including copyrights."

03/02 Received a response from Michael Beebe that any codes submitted by Alternative Link would be owned by AMA because CPT code development panel would revise any information supplied by Alternative Link. Noted that Michael Beebe did not address the five issues asked by Synthia Molina to begin discussions on code integration.

03/20/02 Contacted the AMA and sought official guidance from Michael Beebe for requesting the integration of approximately four thousand ABC codes into CPT before the deadline for CPT coding applications.

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04/03/02 Received guidance from the AMA on the 4/04/04 due date for the CPT application. Made the deadline despite the late notice and suggested that the AMA refine its code application process to reflect non-MD services. Pointed out that the current CPT application process had a physician bias that effectively excluded alternative medicine and nursing services due to the CPT application requirement that peer reviewed articles and evidence of medical effectiveness be attached to each code request. Noted that the code application process was also designed to submit one code at a time and would have resulted in approximately 20 typed pages of information for each code request for an estimated four thousand codes.

04/05/02 Received word from Michael Beebe suggesting that Stanley Nachimson and the AMA meet with Alternative Link following the upcoming NCVHS meeting to further discuss collaboration.

04/10/02 Testified before the NCVHS Security and Standards Subcommittee and outlined steps Alternative Link had taken to comply with HIPAA requirements and DSMO directives. Heard AMA testify that it wanted to collaborate with Alternative Link to add codes for alternative medicine and nursing. Received NCVHS guidance to collaborate with the AMA on code set integration. Met with Karen Trudel and Stanley Nachimson of CMS/HHS following the NCVHS meeting, along with Michael Beebe and Jack Emery of the AMA. Expressed longstanding desire and multiple attempts to work collaboratively with the AMA. Noted past AMA behavior that could be interpreted as predatory. Noted that current interest in collaboration could be a political ploy by the AMA. Heard from Michael Beebe about new AMA leadership and was told the AMA sincerely wanted to collaborate with Alternative Link. Was told by Karen Trudel that she feared the collaboration might fail and no progress would be made by the next NCVHS meeting. Heard CMS state that the ABC codes had intellectual property value and value to the industry and advise the AMA to acknowledge that value in the code set integration process. Heard Michael Beebe agree to comply. Committed to Karen Trudel to make a sincere and responsible effort at collaboration since this could be in Alternative Link's, the AMA's and the public's best interest, if executed in a manner that prevented systemic bias. Expressed a concern about potential physician biases and the risk of dealing with the AMA without assistance/witness. Accepted a CMS/HHS offer for a facilitator. Agreed to work with Stanley Nachimson. Suggested the AMA had more attorneys and were better positioned to draft legal agreements. Suggested macro-level business issues should be addressed before micro-level code set integration issues. Heard Michael Beebe commit to AMA drafting of a non-disclosure and non-compete agreement in support of the collaboration, to treat business issues and code set issues separately and to meet face-to-face in Chicago on May 1st (on business issues) and May 14th (on code set integration issues).

04/16/02 Participated in an AMA telephone call facilitated by Stanley Nachimson, CMS; with Michael Beebe, Jack Emery, Andrea Cooper-Finkle of AMA; Synthia Molina, Melinna Giannini, Joe Gallagher and David Webster of Alternative Link. Learned the AMA would not consider integrating ABC codes into CPT and would not consider compensating Alternative Link for any development of alternative medicine or nursing codes. Learned the AMA was suggesting a special licensing agreement to allow Alternative Link to crosswalk ABC codes and CPT codes and facilitate use of Alternative Link's code by code legal scope of practice information. Explained that, without sufficiently granular CPT codes for the crosswalk, this offer was meaningless. Heard Stanley Nachimson suggest that the AMA review ABC codes and the code development process before concluding that ABC code terminology had no value to AMA. Heard Michael Beebe argue that the ABC code development process was substandard. Asked the AMA for a non-disclosure and non-compete agreement to enable Alternative Link to explain the ABC code development and practitioner interface process to the AMA. Heard Stanley Nachimson ask the AMA to reconsider the value of the ABC code development process and sign a mutual non-disclosure agreement.

04/17/02 Received suggestions from Stanley Nachimson regarding the scheduled May 1, 2002 face to face meeting in Chicago.

04/26/02 Received an AMA letter that misrepresented the purpose and intent of the mutual non-disclosure agreement proposed by Alternative Link and stated that a non-compete agreement would trigger an illegal act. Noted that the AMA was restating that the CPT editorial process was the only valid way to develop codes.

04/27/02 Received several position statements about CPT code development process from practitioner groups and coalitions that did not view the CPT editorial process as fair. Sought guidance from Stanley Nachimson on how to support more constructive negotiations and what to do about the AMA's decision to cancel the first scheduled meeting in Chicago.

04/30/02 Received an email from the AMA canceling the next day's meeting. Cancelled flights to Chicago for May 1 meeting because the AMA said it would not view a meeting as productive until it received a response to its latest letter.

05/01/02 Sent a response letter to the AMA. Disagreed with the AMA stance that the CPT code development process was the only legitimate way to create codes for non-MD providers; again invited the AMA to review ABC code development process (assuming a non-disclosure agreement); pointed out that the AMA's statement that a non-compete was illegal was misleading and taken out of context; and asked that the AMA reconsider the benefits of collaboration and other issues pertaining to framing meaningful collaboration.

05/06/02 Received an email from the AMA that canceled the May 14th meeting and proposed an AMA-led Alternative Therapies Workgroup to develop a competing set of alternative medicine codes from scratch, with or without the participation of Alternative Link, but with no compensation for Alternative Link's participation or intellectual property.

05/29/02 Received an AMA response to a prior Alternative Link letter the day before a scheduled East Coast testimony.

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05/30/02 Testified before the NCVHS. Told the Subcommittee about the AMA's change of position, lack of follow through and predatory behavior. Offered to work with the AMA at a higher level than the CPT Editorial Process or to integrate ABC codes into HCPCS as an immediate solution to a public health need, prevailing business need and congressional challenge. Noted the existence of a non-profit organization established in 1999 to assume code terminology development and management. Heard NCVHS direct CMS to reconsider integrating ABC codes into HCPCS.

06/02 Called CMS and left word with Kaye Riley's assistant asking how Alternative Link could best participate in the CMS code set integration evaluation process.

06/02 Received an irate telephone call from Laurie Feinberg who said Alternative Link had suggested the codes would be integrated rather than evaluated for potential integration. Explained to Dr. Feinberg that Alternative Link understood the need to evaluate the potential for integration and suggested we jointly address the issue in two phases: 1) address business issues to support code set licensing if that were appropriate and 2) address technical aspects of code set integration. Heard that Dr. Feinberg was not the appropriate individual to address business issues and did not know who was. Asked if Alternative Link should seek guidance from the Subcommittee and was told that we should. Asked how we could help in the code set integration evaluation process. Was told that Dr. Feinberg would get back with us within a couple of weeks.

06/02 Called Karen Trudel and Simon Cohn to get guidance on how to address business issues in the code set integration evaluation process. Was told by Karen Trudel that she did not know of an appropriate contact. Was told by Simon Cohn that Kaye Riley would be a good contact on the business issues related to evaluation of code set integration potential. Also asked for confirmation of Subcommittee directives in the May 30th meeting. Was given slightly contradictory overall guidance by Karen Trudel and Simon Cohn. Asked Marjorie Greenberg for clarification and was told she would respond by week's end.

06/17/02 Wrote to Michael Beebe at the AMA and asked for an update on the Alternative Therapies Workgroup. Wrote that if the Workgroup was moving forward, Alternative Link wanted to be included. Suggested the AMA and Alternative Link coordinate to avoid being at crossed purposes and to ensure both organizations supported public health, business needs and congressional intent under HIPAA.

06/24/02 Received email from Michael Beebe at the AMA noting that the AMA was proceeding with the Alternative Therapies Workgroup and would notify Alternative Link of the first meeting.

06/02 Left a message for Kaye Riley asking for help on business issues related to the code set integration evaluation.

06/02 Received a message from Dr. Feinberg that suggested our contacting Kaye Riley was somehow inappropriate and reiterating her authority in code set integration evaluation.

06/02 Left a message for Dr. Feinberg explaining that an NVCHS Subcommittee member had suggested we contact Kaye Riley about the business issues.

06/28/02 Left a message for Karen Trudel asking how to resolve the business issue contact challenge with Laurie Feinberg, noting that Alternative Link was concerned about the perception of Laurie Feinberg's impartiality given Laurie Feinberg's role in the CPT Editorial Panel, and asking for clarification of the Subcommittee position and directives from May 30th.

06/02 Received a call from Stanley Nachimson on behalf of Karen Trudel. Explained the challenges and asked Stanley Nachimson to resume the role of facilitator since Alternative Link was having difficulty getting responses from the NCVHS Subcommittee and CMS. Asked Stanley Nachimson to help Alternative Link better understand the role of decision-makers, the evaluation criteria and the evaluation process to get the process out of a "black box." Suggested a conference call with the NCVHS Subcommittee or some other approach he might view as helpful.

06/27/02 Emailed Marjorie Greenberg, Karen Trudel, Kepa Zubeldia and Simon Cohn asking for written clarification of the Subcommittees position and directives vis-à-vis the May 30th hearing.

07/02/02 Received a brief summary from Marjorie Greenberg that differed substantially from the position and directives of the NCVHS Subcommittee noted in Alternative Link notes and the NCVHS Subcommittee transcripts from May 30th.

07/08/02 Left message for Laurie Feinberg asking for an update on the status of the code set integration evaluation process, since weeks passed since her commitment to call back.

07/08/02 Left a message for Marjorie Greenberg asking for call back to address discrepancy in Subcommittee position and transcripts and wanting to address the CMS "black box" around the code set integration evaluation process.

07/08/02 Received an email from Marjorie Greenberg suggesting that the May 30th Subcommittee transcripts and her summary matched.

07/12/02 Left another message for Laurie Feinberg asking for an update on the status of the code set integration evaluation process.

07/02 Received a message from Kaye Riley saying that she had told Alternative Link in the past that the ABC codes would not work with HCPCS and reiterating that they would not work.

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07/22/02 Learned from Stanley Nachimson that he spoke with Kaye Riley and that she and Laurie Feinberg did not believe the code set belongs in HCPCS and that Laurie Feinberg would be writing a formal letter of explanation. Learned that Kaye Riley and Laurie Feinberg planned to note that HCPCS were supply codes and ABC codes were procedure codes and planned to recommend that Alternative Link work with the AMA to get CPT codes for ABC code terminology. Suggested that Stanley Nachimson ask Kaye Riley and Laurie Feinberg why the American Dental Association procedure codes were acceptable in HCPCS and how Alternative Link could be expected to renew discussions with the AMA at the CPT Editorial Process level when the prior negotiations had been unsuccessful. Asked for clarification of decision-makers, evaluation criteria and the evaluation process to get the process out of a "black box." Learned that Stanley Nachimson would address these questions with Kaye Riley and Laurie Feinberg.

07/24/02 Received a message from Stanley Nachimson saying that a committee would hold an open meeting about coding in late September.

08/02 Asked for confirmation that the HCPCS coding panel would hold an open meeting in September to review the ABC codes. Received clarification from Stanley Nachimson that the HCPCS coding panel would not be holding an open meeting but that CMS would be testifying to the Subcommittee in late September. Learned that Kaye Riley and Laurie Feinberg had not made any new points relative to the questions Alternative Link had raised about the American Dental Association codes. Asked Stanley Nachimson to bring up the American Dental Association and Blue Cross Blue Shield Association procedure codes with Kaye Riley and Laurie Feinberg. Asked for written clarification of decision-makers, evaluation criteria and the evaluation process.

08/06/02 Received an email from Stanley Nachimson saying that Kaye Riley had reported to him that the HCPCS National Panel had reviewed the ABC codes and concluded that 1) ABC codes were procedural while HCPCS codes were supply related, and 1) Alternative Link could apply for HCPCS supply codes one code at a time.

08/06/02 Reiterated in an email to Stanley Nachimson the inconsistencies in the reported rationale for ABC codes not fitting into HCPCS. Asked for written notice of the organizational hierarchy, code set evaluators, review criteria and review process to help Alternative Link report back to interested Alternative Link constituency groups and to provide Alternative Link with enough information to help to resolve any misunderstandings or challenges. Also described the challenges of being redirected to the AMA and CPT Editorial Process.

08/09/02 Left messages with Laurie Feinberg, Kaye Riley, Karen Trudel, Stanley Nachimson and others in HHS requesting face-to-face meetings. Advised them that Melinna Giannini and Synthia Molina were on assignment in Washington DC and would be in town until significant progress was made on the code set review and a direction was clear. Indicated the first part of the week of 08/12/02 was reserved to work with HHS through established channels and, thereafter, Alternative Link would work up and down the hierarchy as needed and would meet with contacts on Capitol Hill and elsewhere to ensure the code set was reviewed and advanced in a timely, responsible and appropriate manner.

08/09/02 Received call from Stanley Nachimson (CMS) indicating he and Jared Adair (CMS) would meet with Synthia Molina, Alternative Link's CEO, on Monday, 08/12/02, at 10:00 a.m. EST.

08/12/02 Held meeting with Jared Adair (CMS), Karen Trudel (CMS), Robert Miller (an ABCcoding constituent) and Synthia Molina (Alternative Link). Was asked the following questions: What is unique about the ABC codes? How should/could/would ABC codes fit into existing HIPAA code sets? What significant gaps exist in the existing HIPAA code sets? What specific interventions do alternative medicine, nursing and other integrative healthcare practitioners need to bill for that are not reflected in current HIPAA code sets (i.e., HCPCS Level I and II codes)? What types of interventions are described by ABC codes? Where could/should/would ABC codes fit within HCPCS, based on type of intervention? For example, do individual codes represent services, procedures, durable medical equipment, supplies or other categories of healthcare deliverables? Concluded that CMS planned to 1) review the ABC codes and terminology that were developed by Alternative Link and the Foundation for Integrative Healthcare in coordination with alternative medicine, nursing and other integrative healthcare thought- and practice-leaders, educational institutions, healthcare associations, licensing organizations, government regulators; 2) evaluate whether ABCcoding categories (e.g., procedures and supplies) describe healthcare interventions that are relevant under HIPAA; 3) determine, on a code-by-code basis, whether the ABC codes and terminology are relevant under HIPAA; 4) determine, on a code-by-code basis, whether ABC codes that are relevant under HIPAA are unique or overlap codes in existing HIPAA code sets (i.e., whether HCPCS Level I or II codes are already available to achieve HIPAA objectives—such as electronic billing—for these interventions or whether new codes are needed); 5) make recommendations on how to ensure new codes that are relevant under HIPAA and could be integrated into HCPCS are made available by October 16, 2003; and 6) identify areas where ABC codes and terminology may or may not support HIPAA compliance and what could be done to better support such compliance.

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08/14/02 Sent thank you email to Jared Adair (CMS) and Karen Trudel (CMS). Summarized understanding that 1) CMS's "macro" goal is to "ensure that by October 16, 2003, services provided by healthcare practitioners have unique codes under HIPAA;" and 2) CMS would report back to NCVHS Subcommittee in late September on the "micro" issues of how ABC codes may or may not be relevant to CMS priorities under HIPAA and may or may not fit within specific areas of HCPCS. Committed to forward a document that summarized in greater detail Alternative Link's understanding of the 8/12/02 conversation and potential next steps to ensure that Alternative Link, the Foundation for Integrative Healthcare, and constituents had reasonable and appropriate expectations about CMS's immediate task and its potential outcomes. Noted that Alternative Link would support CMS efforts by 1) ensuring CMS had the 2003 version of the ABC codes, and 2) clarifying where Alternative Link believed gaps existed in the current HCPCS codes (relevant to HIPAA and alternative medicine, nursing and other integrative healthcare practitioners).

08/16/02 Received email from Jared Adair (CMS) that noted that CMS will not report to the NCVHS on how the codes "...may or may not be relevant to CMS priorities..." and will only address whether the ABC codes fit with HCPCS.

08/17/02 Sent an email to Jared Adair (CMS) thanking her for her clarification and asking the following questions: 1) If CMS finds that the codes do fit within HCPCS, and if the NCVHS Subcommittee views that as a potential solution, does she have a sense of what CMS' position or challenges might be regarding integrating this code set under HIPAA? 2) If CMS finds that the codes do not fit within HCPCS, if CMS would face challenges in integrating this code set under HIPAA, or if the NCVHS Subcommittee does not ultimately view code set integration as a potential solution, does she have a sense of what other options would be available to ensure public, industry and national needs are addressed in as timely a fashion as possible?

08/19/02 Received an email from Jared Adair (CMS) saying that CMS would focus on the task at hand and offering no guidance on or mention of the two questions.

08/19/02 Sent an email to Jared Adair (CMS) thanking her for her timely response, notifying her that Alternative Link would pursue answers to the posed questions through other channels, and inviting her to guide the process or comment at her earliest convenience if it created some concerns.

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EXHIBIT T –TESTIMONIES TO NCVHS PROVIDED EVIDENCE THAT ABC CODES MET STANDARDS FOR HIPAA CODE SETS

(*Note: ABC codes used to be referred to as "ABCcodes."*)

Alternative Link's Written Testimony to NCVHS Subcommittee

4/10/02

A Gap in the Code Sets

Why ABC codes are Needed to Support Administrative and Financial Transactions Related to Alternative Medicine, Nursing and Other Non-MD Interventions

What is the purpose of Alternative Link's testimony?

Alternative Link seeks designation of the ABC codes as an additional national administrative code set under HIPAA.

Alternative Link offers answers to likely concerns of the NCVHS:

Has Alternative Link followed the directives of the DSMOs?

Does a gap exist in coding?

Why does a gap exist?

How should the gap be filled?

How much overlap exists between ABC codes and existing standard code sets?

What guidelines are in place for use of the codes?

What experience did Alternative Link have with the DSMOs?

How could the DSMO process be improved?

What else should the DSMOs and NCVHS understand?

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Has Alternative Link followed the directives of the Designated Standard Maintenance Organizations (DSMOs) specified in Change Request Numbers 137 (dated 1/31/01) and 493 (dated 9/20/01)?

Yes, Alternative Link has followed the directives of the DSMOs specified in Change Request Numbers 137 (dated 1/31/01) and 493 (dated 9/20/01). In the following sections, Alternative Link reviews past actions and summarizes more recent actions not yet reported to the DSMOs.

The DSMOs gave Alternative Link four (4) directives.

Indicate why HCPCS, CPT and NDC are not meeting business needs.

Approach HCPCS coding authorities to see if ABC codes could be incorporated into HCPCS.

Approach CPT coding authorities to see if ABC codes could be incorporated into CPT.

Demonstrate health plan [and other user] support for "these categories" (i.e., alternative medicine, nursing and other non-MD interventions).

Directives #1, 2 and 3. In relation to DSMO Directives #1, 2 and 3, Alternative Link has communicated to the DSMOs both verbally and in writing why existing HCPCS and CPT codes and coding systems are not meeting all of the healthcare industry's critical business needs. Alternative Link notes below why existing NDCs and the NDC coding system are not meeting these same business needs.

HCPCS. To summarize, HCPCS[364] "contains codes for medical equipment and supplies; prosthetics and orthotics; injectable drugs; transportation services; and other services not found in CPT."[365] HCFA/CMS does not develop procedure codes. This fact was supported verbally on 09/07/01 and in writing on 03/13/02 by C. Kaye Riley, HCPCS Coordinator.[366] [367]

CPT. "CPT: Physicians' Current Procedural Terminology is used by physicians and other healthcare professionals to code their services for administrative transactions. The CPT panel is comprised of 15 *physicians*, 10 nominated by the AMA and one each nominated by Blue Cross/Blue Shield of America (BCBSA), the HIAA, HCFA[368] and AHA. Meetings are not open to the public."[369]

On 3/19/02--following written directives of the DSMOs and verbal directives from HIPAA experts Stanley Nachimson of HCFA/CMS and Maria Ward, Chair of the DSMOs--Alternative Link approached Michael Beebe, Director, CPT Editorial and Information Services of the AMA, in the interest of collaborating with the AMA.[370]

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In this interaction, Alternative Link found the AMA/CPT to be outwardly supportive but factually unresponsive to concerns and direct questions posed via telephone and followed up in writing.

In an email communication, dated 03/20/02--copied to the HIPAA experts –the Director expressed support for a collaborative relationship but did not answer five direct questions posed by Alternative Link in a telephone conversation on 03/19/02.

These questions were as follows:

How can we [the AMA and Alternative Link] jointly ensure code review is timely, so that coding is quickly available for health services research, tracking and payment of services currently being rendered, and actuarial analyses by payers and others?

How can we efficiently categorize, assess and incorporate the 4000 service and supply codes Alternative Link has already researched and validated?

How can we address the variability in state licensing requirements and scope of practice laws that affect non-MD interventions? (In developing the ABC codes, Alternative Link captured code and practitioner specific data on this variability. Allopathic care does not face such state-by-state variability and, consequently, the CPT application process does not account for interventions that have state endorsement but may or may not have national acceptance. If the answer is to this challenge is to use Category II or III codes, how could we do so without prompting insurers to deny claims because the interventions are coded as measurement tools or as investigational or experimental care?)

How can we ensure that the code review process does not subject non-MDs and coding to allopathic physician biases when the CPT® Editorial Panel is made up solely of physicians and the coding application instructions include wording such as, "The inclusion of…(Category I)…codes is generally based upon the procedure being consistent with contemporary medical practice and being performed by many physicians in clinical practice in multiple locations."

How can we ensure Alternative Link's intellectual property is protected when the code application requires us to prospectively "assign to the AMA all rights including copyrights" when the ABC codes are already copyright protected?

The CPT Director's email stated that AMA was interested in cooperating with Alternative Link, but since it did not address the direct questions the Director verbally had agreed to answer in writing, a collaborative relationship was not established.[371] On 3/20/02, Alternative Link made a second attempt to establish a collaborative relationship by sending the Director an email and letter to reiterate Alternative Link's need for written answers to the direct questions. Alternative Link received no response.

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On 04/02/02, Alternative Link left a voicemail message for the Director to ask if any communications were forthcoming and to reiterate Alternative Link's desire to collaborate. Alternative Link remains open to a collaborative relationship with the AMA.

NDC. National Drug Codes "are used in reporting prescription drugs in pharmacy transactions and some claims by healthcare professionals."[372] NDCs do not address procedures and therefore will not support procedures delivered by…(IHCPs). NDCs cannot be used effectively for botanicals, nutritional supplements and homeopathic remedies because many of these are delivered in bulk form and most are regulated as food substances and not drugs. Therefore, NDCs cannot accommodate supplies associated with…(IHC). Further, NDCs are no longer required in X12N claims transactions because NDCs are not widely used by the health insurance industry on claims transactions between healthcare practitioners and insurance payers. For these reasons, NDCs will not support HIPAA code set objectives related to alternative medicine, nursing and other non-MD interventions.

Directive #4. In relation to DSMO Directive #4, Alternative Link has already demonstrated "support for health plans supporting/paying for these categories."[373] Alternative Link's demonstration of this support was confirmed when the DSMOs wrote that the only outstanding item in relation to their four directives was the request that Alternative Link once again approach CPT, as described above.[374] A copy of the DSMOs' communication is available upon request.

To demonstrate this and other industry support, Alternative Link submitted letters from industry thought- and practice-leaders, including the following:

American Bar Association's Committee on Complementary and Alternative Medicine
American Massage Therapy Association
American Nurses Association
American Preventive Medical Association
Association of Bodywork & Massage Professionals
Midwives Alliance of North America
State Associations of Acupuncture and Chiropractic

Additional evidence of the demand for ABC codes and the ABCcoding system's value to health plans can be found in "Comments on Proposed Rule, Health Insurance Reform Standards for Electronic Transactions (Refer to File Code HCFA-0149-P" prepared by Alternative Link and submitted to HCFA/CMS on 06/30/98. This document is available upon request.

Further, government interest in the ABC codes and coding system is demonstrated by the inclusion of the ABC codes in the National Library of Medicine's Unified Medical Language System.

Finally, growing market interest in the ABC codes and ABCcoding system is demonstrated by Alternative Link's pilot programs and/or working relationships with the following organizations:

An HMO/PPO/IDN/TPA that Serves Boeing, Cessna, Leer, Raytheon and Other Large, Medium and Small Employers (Preferred Health Systems)

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A National PPO Network (American Healthcare Alliance)
Two National Clearinghouses (Mitchell Medical and NaviMedix)
Two Medical Publishers (Delmar/Thomson Learning and Relative Value Studies, Inc.)
Several Industry-Leading Consulting Firms (e.g., PricewaterhouseCoopers)
Numerous Integrative Medicine Centers and Academic Research Institutions (e.g., University of North Carolina)

To ensure the ABC codes would provide ongoing value in accordance with the objectives of HIPAA, Alternative Link has been active in the following Standard Development Organizations (SDOs) and standard-influencing organizations:

American National Standards Institute/Accredited Standards Committee (ANSI X12N)
Health Level 7 (HL7)
Data Interchange Standard Association (DISA)
Computer-based Patient Record Institute (CPRI)
American Health Information Management Association (AHIMA)
American Holistic Health Association (AHHA)

Supplemental information supporting this section and the value of the code set is provided in a document entitled, "Testimony to the National Committee on Vital and Health Statistics by the American Nurses Association and Alternative Link Regarding the ABC codes for Alternative Medicine and Nursing," dated 02/06/02, prepared for testimony that was originally scheduled for 02/06/02. This document is available upon request.

To fully understand the value of ABC codes and the limitations of using existing standard code sets, the Committee is encouraged to review three directly related publications available from Alternative Link, upon request:

The CAM and Nursing Coding Manual, ©2001, Alternative Link and Delmar/Thomson Learning

The State Legal Guide to Complementary and Alternative Medicine and Nursing, ©2001, Alternative Link and Delmar/Thomson Learning

Relative Values for CAM and Nursing, © 2001, Relative Value Studies, Inc.

These publications show that the code set 1) contains heretofore unavailable and gravely needed information, 2) is widely distributed, 3) is affordable, and 4) is ready to be implemented on a national basis.

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To summarize, the above notes and referenced documents demonstrate that Alternative Link has:

Indicated why HCPCS, CPT and NDC are not meeting business needs.

Approached HCPCS coding authorities to see if ABC codes could be incorporated into HCPCS.

Approached CPT coding authorities to see if ABC codes could be incorporated into CPT.

Shown health plan support for "these categories" (i.e., provided evidence of widespread industry support for ABC codes to facilitate transactions and capture data related to alternative medicine, nursing and other non-MD interventions).

Does a gap exist in coding?

Yes, a gap exists. This is evident because adding ABC codes as a HIPAA-named code set would accomplish each of the ten (10) guiding principles for standards noted in the Federal Register.[375]

If the existing standard code sets were sufficient, the ABC code set would provide no incremental benefit in relation to these principles.

However, ABC codes would add considerable incremental value.

ABC codes will:

Improve the efficiency and effectiveness of the healthcare system by leading to cost reductions for and improvements in benefits from electronic healthcare transactions.[376]

The named code sets do not deliver all of the efficiency and effectiveness needed by the healthcare system. ABC codes supplement these code sets to improve the way the industry transacts business in relation to alternative medicine, nursing and other non-MD interventions.

For example, while CPT theoretically could develop numeric codes for these interventions, CPT is missing a critical design and data element that is essential for supporting regulatory compliance, provider contracting, utilization management, claims management, actuarial analyses and outcomes research.

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That is, if CPT codes were developed for alternative medicine, nursing and other non-MD interventions using existing CPT numeric structures, the CPT codes would not generate the functionality and value that the industry needs.[377] [378] The needed design and data element—an alphanumeric modifier that identifies practitioner type to reflect state-specific licensing/terminology—is included in ABC codes. This modifier is paired with a state field on a standard claim form or transaction to ensure the claim is within the provider's legal scope of practice. It offers the added value of supporting outcomes research by practitioner type without compromising HIPAA privacy standards.

Thus, incremental code set efficiency and effectiveness are assured by ABC codes because these codes not only fit into CPT data fields and work with existing healthcare information systems, but also provide unique claim edit/scrub functionality required to assure compliance with state scope of practice laws. This unique functionality has been broadly tested and is urgently needed by the industry 1) to ensure compliance with HIPAA fraud and abuse regulations and 2) to support meaningful actuarial analyses in support of benefit plan design and cost-effective, evidence-based and integrative healthcare.

Meet the needs of the health data standards user community, particularly healthcare providers, health plans and healthcare clearinghouses.[379]

Alternative Link's ABC codes meet the needs of the health data standards user community, particularly healthcare providers, health plans and healthcare clearinghouses. Alternative Link received verification from healthcare providers, health plans and clearinghouses that the ABC codes deliver missing information; add significant value in managing access, quality and cost; and would be readily adopted if named a code set under HIPAA.

Further, Alternative Link has compiled market data and trade journal articles that point to the need for the functionality delivered by ABC codes.

Evidence of this support is available upon request.

Be consistent and uniform with other HIPAA standards—their data element definitions and codes and their privacy and security requirements—and, secondarily, with other private and public health data standards.[380]

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ABC codes were designed for this specific purpose. Alternative Link has been involved with healthcare standard-setting organizations since the Company's inception. These organizations include:

American Health Information Management Association (AHIMA)
American Holistic Health Association (AHHA)
American National Standards Institute/Accredited Standards Committee (ANSI X12N)
Computer-based Patient Record Institute (CPRI)
Data Interchange Standard Association (DISA)
Health Level 7 (HL7)

The design, functionality and use of ABC codes supports the goals of these organizations. Evidence of consistency and uniformity with industry standards is available upon request.

Have low additional development and implementation costs relative to the benefits of using the standard.[381]

ABC codes have low additional development and implementation costs relative to the benefits of their use as a standard. ABC codes have the same number of data elements as CPT/HCPCS codes, fit into CPT/HCPCS data fields, and can be easily downloaded into existing healthcare information systems.

However, ABC codes support even greater functionality than CPT/HCPCS codes.

Because of this, the benefits of using ABC codes as a standard code set far exceed development and implementation costs. The ABC codes require virtually no alterations to health industry stakeholders' software applications, healthcare information systems, or standard operating procedures. Yet, ABC codes allow health industry stakeholders to address the care delivered by alternative medicine, nursing and other non-MD providers in a manner that supports state law—a capability heretofore unattainable.

NCVHS may wish to note that the population of alternative medicine, nursing and other non-MDs is more than triple the population of allopathic physicians. Public demand for complementary and alternative medicine (not including nursing and other non-MD interventions) is significantly higher than public demand for primary care delivered by allopathic physicians, and the demand for CAM is growing more quickly than that of allopathic care.

Further, by using ABC codes in combination with standard code sets, health industry stakeholders will begin to capture evidence of the relative safety, efficacy and cost-effectiveness of unconventional, conventional and integrative healthcare.

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Thus the benefits of integrating…(integrative healthcare) interventions into mainstream healthcare, using ABC codes, are significant.

Evidence of this is available upon request.

Be supported by an ANSI-accredited standards developing organization or other private or public organization that will ensure continuity and efficient updating of the standard over time.[382]

ABC codes are supported by an ANSI-accredited standards developing organization, as well as other private and public organizations. This fact will ensure continuity and efficient updating of the code set over time.

ABC codes were voted into ANSI X12N 004022 and are included in the implementation guides for ANSI X12N 004050.

Additional ABC codes may be requested by anyone and are systematically developed in coordination with academic institutions, centers of excellence and specialty associations representing alternative medicine, nursing and other non-MDs.

Updating of ABC codes is assured by a publicly available coding application and a fully developed coding process described in Alternative Link's publications and website (www.alternativelink.com). The coding process is inclusive and supports over a dozen licensed unconventional and/or non-MD care providers.

Evidence of appropriate organizational support and a copy of the coding process are available upon request.

Have timely development, testing, implementation and updating procedures to achieve administrative simplification benefits faster.[383]

As noted above, the development, testing, implementation and updating procedures for ABC codes have been verified by the National Library of Medicine, Unified Medical Language System.

Further, users have installed and are using the ABC code database.

Thus, the code set is fully functional and market-ready, and it will rapidly deliver administrative simplification benefits.

Evidence of this is available upon request.

Be technologically independent of the computer platforms and transmission protocols used in electronic health transactions, except when they are explicitly part of the standard.[384]

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ABC codes are published in a coding manual and are technologically independent of the computer platforms and transmission protocols used in electronic health transactions. The codes can be used electronically or on standard paper claim forms.

Evidence of this is available upon request.

Be precise and unambiguous, but as simple as possible.[385]

ABC codes are precise. For example, CPT offers 4 codes that describe chiropractic manipulation, based on body regions only. In comparison, ABC codes offers 5 additional codes that describe chiropractic manipulation, based on body regions and types of tissue, as well as 16 codes that describe joint adjustments, 3 that describe strapping techniques, and 17 that address mobility treatments.

ABC codes are unambiguous. Each alpha symbol has a specific meaning and each meaning is echoed in the procedure description. For example, CCAAJ refers to soft tissue manipulation (AJ, in fourth and fifth positions, representing the specifics of the intervention), Chiropractic manipulation (A, in the third position, representing the general type of intervention), Chiropractic services (C, in the second position, representing the care subcategory), Practice specialties (C in the first position, representing the care category).
The expanded definition for CCAAJ is "The application of force by hand or device to soft tissue structure to restore normal anatomical and/or physiological structure and function."[386]

ABC codes are simple. They include five alphabetic characters that identify the service or supply. ABC codes are modified by two alphanumeric characters that serve to identify the practitioner type. CCAAJ indicates a chiropractic intervention. The modifier "1A" indicates the service was delivered by a licensed chiropractor. The 5-character alpha, 2-character modifier, when paired with the state code on a claim form, can be read by a claim edit/scrub application to determine whether that intervention is legal in the noted state when delivered by a particular practitioner type. For example, if the code was "CCAAJ-1A" and the state was "MI" for Michigan, the claim would be denied because chiropractors in Michigan may only work on the spine. However, if the same code was used in New Mexico, the claim would pass because chiropractors are considered primary care practitioners in New Mexico and may use "all natural agencies to assist in the healing act."

Further evidence of code set precision, lack of ambiguity and simplicity is available upon request.

Keep data collection and paperwork burdens as low as feasible.[387]

The ABC codes keeps data collection and paperwork burdens as low as feasible—and significantly lower than the burden still associated with current code set standards.

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The ABC codes are sufficiently granular to avoid the need for generic CPT codes that must be supplemented by written documentation. For example, without ABC codes, claims adjusters (reviewing claims with generic CPT codes) must intervene in an otherwise automated processes to identify the intervention, establish acceptance of the intervention as valid medical practice, and research the legality of the delivery of the coded intervention by that practitioner type in that state. If the adjuster fails to do this, the insurance organization risks processing fraudulent claims and may incur substantial fines and, potentially, criminal indictment.

ABC codes allow for automated performance of these critical claim review and verification steps.

Further, expanded definitions associated with ABC codes greatly reduce the need for written documentation.

Finally, automated data warehousing, querying and analytical capabilities associated with ABC codes reduce the need for manual data collection and paper record review to perform actuarial analyses needed for benefit plan design and development of cost-effective, evidence-based and integrative healthcare.

Further evidence of the data collection and paperwork reduction associated with ABC codes is available upon request.

Incorporate flexibility to adapt more easily to changes in the healthcare infrastructure (such as new services, organizations and provider types) and information technology.[388]

ABC codes are flexible and accommodate changes in the healthcare infrastructure, especially the emergence of new services and provider types. In fact, the ABC code application and development process captures data on emerging technologies, practitioners and delivery systems far more quickly than the processes associated with existing standard code sets (CPT/HCPCS).
ABC codes may be proposed by individuals, academic and health services research institutions and centers of excellence just as new interventions are discovered.

Further, ongoing review of state law ensures practitioner-identifying modifiers are added as states grant licensure to new categories of healthcare practitioners.

If new healthcare organizations emerge, relevant codes can be assigned on an as needed basis.

If new information technology emerges, the codes can be readily incorporated since they consist of machine-readable alphabetic and numeric characters.

Because of its alphabetic structure, the ABCcoding system can accommodate over 11 million new services and supplies.

Further evidence of ABCcoding flexibility and adaptability is available upon request.

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To summarize, then, the gap in code set standards exists because current code sets (CPT, HCPCS, NDC, CDT) do not sufficiently describe alternative medicine, nursing and other non-MD interventions delivered by licensed healthcare professionals. Further, current code sets cannot incorporate the imbedded intelligence needed to facilitate claims edits/scrubs required for …(integrative healthcare) claims. Finally, CPT, HCPCS and NDC application processes are not designed to accommodate developments in alternative medicine, nursing and other non-MD practices. Thus, current code sets are inadequate to serve the industry's needs.

Without the detailed and structured coding offered by ABC codes, the industry is forced to:

Manually adjudicate claims—even if those claims are submitted electronically.

Overlook interventions performed by …(integrative healthcare);

Use relatively "generic" codes that do not adequately describe their interventions; and

Refer to inaccurate codes that are only gross approximations of services or supplies.

The first circumstance—intervening manually to adjudicate claims—undermines the very purpose of standardized transactions and code sets and may compromise patient privacy.

The second circumstance—overlooking non-MDs—comprises the intent of HIPAA. It a) disenfranchises…(integrative healthcare practitioners) from the benefits of administrative simplification, b) creates patient privacy challenges by placing patient data outside the protections afforded to electronic information, and c) compromises efficiencies that could be achieved if the healthcare system could capture services from this category of practitioners as part of its efforts to generate cost-effective, evidence-based and integrative healthcare.

The third circumstance—use of relatively generic codes—results in a loss of information needed to efficiently and effectively manage care, claims and outcomes. The point of codes and code sets is to describe interventions in a manner that supports administrative simplification, claims payment and public health. Generic codes lump different interventions into a relatively useless pool of data and therefore do not accomplish this.

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The fourth circumstance—use of inaccurate codes that describe only remotely related interventions—results in erroneous data that undermines the reliability of healthcare information, compromises actuarial analyses and—perhaps worse—promulgates fraud and abuse (i.e., illegal use of codes).[389]

Just as some 8,000 CPT codes are needed to adequately describe the interventions performed by allopathic physicians, thousands of ABC codes are needed to adequately describe the interventions performed by dozens of categories of alternative medicine, nursing and other non-MDs. Allopathic physicians receive broad and specialized training in their fields, which are reflected in CPT codes. Licensed alternative medicine, nursing and other non-MDs also receive broad and specialized training in their fields. This non-MD training is reflected in ABC codes, but is not reflected in CPT codes.

ABC codes currently address some 4,000 …(integrative healthcare) services and supplies delivered by over a dozen practitioner types. The developers of ABC codes already have relationships with thought- and practice-leaders representing other categories of …(integrative healthcare practitioners) and have begun categorizing their patterns of care for the purposes of expanding the ABC codes to address their needs. Thus ABC codes describe interventions that CPT codes do not describe, serve practitioners that CPT codes do not serve and support developments that CPT codes cannot yet support.

Why does the gap exist?

Of all the code set standards, CPT is the closest to ABC codes. That notwithstanding, CPT does not adequately serve market needs related to alternative medicine, nursing and other non-MD interventions. This fact appears to be a result of two things: 1) the AMA's focus on allopathic physician care and 2) CPT code design.

The AMA focuses on physician membership and allopathic medicine. Alternative Link believes this is evident in the AMA's patterns of litigation[390] as well as their corporate communications.[391]

The AMA's CPT code design and application process do not lend themselves to timely or effective development of …(integrative healthcare) codes. First, as noted above, the CPT codes themselves are structurally incapable of including coded "intelligence" required by the industry to manage care, claims and outcomes associated with …(integrative healthcare) interventions.

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Second, the CPT application process supports submission of one to several codes at a time and the market needs thousands of codes to support current healthcare insurance benefit plans and transactions. The few …(integrative healthcare) codes that have been developed under CPT are so "generic" that they do not adequately describe the interventions they are purported to code. These codes are therefore ineffective in achieving the goals of HIPAA, let alone of industry stakeholders. This fact is evident in the benefit plan "carve outs" that healthcare insurance organizations have had to use for …(integrative healthcare) benefits.

That is, insurers have had to put caps on numbers of …(integrative healthcare) visits and dollars spent for visits because the insurers cannot tell what is being delivered and whether the delivered services or supplies have any meaningful outcomes.

All of this suggests that considerable strategic repositioning would be required by the AMA and considerable reengineering would be required of its CPT coding process to accommodate healthcare industry needs related to alternative medicine, nursing and other non-MD interventions.

This situation creates a public health challenge on several levels.

First, codes document care. The absence of a comprehensive code set for …(integrative healthcare) services forces caregivers to deliver care without reliable evidence of what works and what does not.

Second, perceiving allopathic physician biases against …(integrative healthcare), patients seldom tell their physicians about non-allopathic healthcare interventions the patients are receiving. When physicians are unaware of …(integrative healthcare) interventions, physicians may make less appropriate care decisions. Care decisions made without full knowledge of patient circumstances can compromise the quality of care patients receive and can affect public health.

Despite these circumstances, public spending suggests that demand for complementary and alternative medicine (not including nursing and other non-MD interventions) is increasing at a compounded annual growth rate of 38%. This means the gap in code sets is becoming more significant and dangerous with time.

<u>How should the gap be filled in a way that would support administrative simplification and public health?</u>

For the reasons noted above, a separate code set is needed for alternative medicine, nursing and other non-MD interventions. Alternative Link believes the ABC codes should be named the standard code set for …(integrative healthcare) interventions. The ABC codes provide functionality that is necessary to support the objectives of HIPAA.

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How much overlap exists between ABC codes and existing standard code sets?

In 1998, Alternative Link licensed a crosswalk to AMA's CPT codes to allow health industry stakeholders to capture data on both ABC codes and CPT codes used by alternative medicine, nursing and other non-MDs. Subsequently, in response to AMA pressure, Alternative Link discontinued the crosswalk, retired most billable ABC codes linked to CPT codes and added non-billable reference codes for X-rays, minor surgeries and diagnostic tests, that direct coders to use CPT codes. These reference codes are needed to allow for appropriate claims edits/scrubs, as described above.

As of 02/28/00, the overlap with AMA's CPT codes was less than 10%. Alternative Link believes this overlap is even lower today, since additional codes have been developed by Alternative Link in areas not addressed by CPT.

What guidelines are in place for use of the codes?

The ABC codes are support by guidelines endorsed by ANSI X12N. ANSI X12N 004022 assigned a code to inform healthcare information systems that ABC codes will follow. ANSI X12N 004050 included an implementation guide that describes how to use ABC codes.

Further, three publications include complete guidelines on development, use, valuation and obsolescence of ABC codes and related information.

These include:
CAM and Nursing Coding Manual published in 2001 by Delmar/Thomson Learning
State Legal Guide to CAM and Nursing published in 2001 by Delmar/Thomson Learning
Relative Values for CAM and Nursing published in 2001 by Relative Value Studies Incorporated.

Finally, the Alternative Link website includes guidelines on the design, development, use, obsolescence and valuation of ABC codes and related information.

What experience did Alternative Link have with the Designated Standard Maintenance Organizations?

Alternative Link found the DSMOs to be difficult to educate about 1) the unique aspects of coding for alternative medicine, nursing and other non-MD services and 2) allopathic physician biases of the AMA that could compromise public health and, potentially, represent restraint of trade.

For example, the DSMOs had difficulty understanding that the ABC codes could fulfill federal mandates under HIPAA and also ensure industry compliance with state laws--and that this was essential to effective functioning of the healthcare system and to public health.

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Further, the DSMOs repeatedly asked Alternative Link to approach the AMA, despite Alternative Link's repeated communications that, in past encounters initiated by Alternative Link in the interest of collaborating, the AMA had exhibited uncooperative and even predatory behavior.

Finally, despite Alternative Link's repeated offers over the last year to attend meetings and be "officially heard" about these matters, the NUCC and NUBC did not schedule time to hear Alternative Link's testimony. (Interestingly, NUCC is permanently chaired by the AMA.)

Without allowing for this testimony, a member of the DSMOs suggested in a public forum that Alternative Link had been somehow inappropriate in its interactions with the DSMOs and code set authorities. That forum—a national HIPAA conference—included dozens of Alternative Link's prospective customers. The public statement by the DSMO member resulted in the loss of a viable lead with a leading insurance organization that was already offering a healthcare insurance benefit related to alternative medicine, nursing and other non-MD interventions—and that had expressed interest in the functionality provided by the ABC codes.

How could the DSMO process be improved?

The DSMO process appears to be designed for organizations with "deep pockets."

Smaller organizations, such as Alternative Link, are hard-pressed to mobilize resources toward educating DSMO membership about the benefits of HIPAA related solutions.

Addressing a similar challenge faced by organizations developing technologies for the public good, the Food and Drug Administration set up a "Division of Small Manufacturers Assistance." This division provides guidance and resources to help smaller organizations comply with federal mandates.

A comparable support mechanism under the DHHS would ensure public health is better served by ensuring that organizations with the best solutions—not just the most money—are able to navigate the DSMO review process and, if worthy, be named as standards.

What else should the DSMOs and NCVHS understand?

Alternative Link remains willing to cooperate and collaborate with other code set authorities and asks only that DSMO and NCVHS leadership work with these authorities to preempt any predatory behavior.

Alternative Link is providing the following editorial (written for an international healthcare technology journal that targets chief information, technology and operating officers at provider and payer organizations) to help committee members understand the unique value of the ABC codes and the importance of naming this code set a standard.

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Improving Clinical and Financial Outcomes in Healthcare

Background

A new set of alphanumeric codes for nursing and alternative medicine and three global trends are improving healthcare accessibility, quality and cost management worldwide.

Alternative Billing Codes, known as ABC codes, offer healthcare leaders one of the most powerful tools available to manage healthcare access, quality and costs. ABC codes reflect three trends in healthcare leadership behavior that generate improvements in the health of populations: 1) use of unconventional and integrative medical practices, 2) use of electronic standards, and 3) reliance on evidence-based medicine.

ABC codes are 5-characters in length and consist of letters that represent thousands of services and supplies used for nursing and unconventional medicine—also known as complementary and alternative medicine (CAM). These codes are supplemented by 2-digit identifiers, called *code modifiers*, that describe the practitioners involved in a particular intervention. For example, ABC code "AEBAD-1E" represents 15 minutes of holistic nutrition provided by a naturopathic physician. The codes and code modifiers are useful in understanding, evaluating and guiding the financing and delivery of CAM interventions. ABCcoding can be expanded to identify practices and products delivered by more than 1,200 different types of healthcare practitioners. The code set offers more than 11.8 million code combinations—enough to describe current and emerging modes of care for centuries to come.

Demand for CAM interventions is increasing worldwide. CAM services and supplies represented by ABC codes include acupuncture and Oriental medicine; Ayurveda; botanical medicine; chiropractic, clinical nutrition; conventional and holistic nursing; holistic medicine; homeopathy; indigenous medical traditions; massage and other manual medicine therapies; mind/body medicine; mental healthcare; midwifery; naturopathy; dietary supplements and nutrition; osteopathy; and physical, occupational and vocational therapy. Related CAM supplies include herbal medicine, dietary supplements, homeopathic remedies, and other products.

ABC codes promote evidence-based medicine to ensure that patients receive the most promising healthcare available. Evidence-based medicine optimizes patient health, reduces costs, and allows healthcare systems to better manage constrained resources. The codes help integrate clinical, operational and administrative processes both within and across organizations. This increases system-wide efficiency; improves clinical, operational and financial decision-making by providing timely insight into the delivery of healthcare services; and results in more favorable outcomes.

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ABC codes fit into the healthcare information systems used by governments, insurance companies, healthcare delivery organizations and healthcare practitioners. Warehoused within those information systems, ABC codes can be mined and analyzed to achieve a variety of desirable endpoints. Among these are 1) understanding how CAM is currently used, 2) determining how unconventional medicine compares in cost-effectiveness to conventional medicine, and 3) developing integrative and evidence-based approaches to improving outcomes.

Using ABC codes, practitioners and administrators gain valuable insight on managing resources and improving efficiency. ABC codes help compile information on each clinical encounter; convert that information into a patient medical record, bill or insurance claim; and automate financial transactions (such as insurance claims processing and payment).

ABC codes and CAM interventions provide new ways for healthcare financing and delivery systems to meet patient demand, improve care and save money.

The majority of the world's population uses CAM as the primary form of healthcare. Demand for CAM is well entrenched in many countries and is rapidly growing in countries that used to rely largely on western medicine. In India, an estimated one-third of the population uses homeopathic medicine, another third uses Ayurvedic medicine and the final third uses western or integrative medicine.[392] In the United States, where western medicine has predominated healthcare for over 100 years, CAM is growing at a compounded annual rate of 38%. In fact, demand for CAM is so great in the US that, in 1997, about 63% more visits were made to CAM practitioners than to primary care physicians (PCPs).[393]

Adoption of uniform code sets varies worldwide. Most countries and organizations code diseases and healthcare conditions using International Classification of Disease codes (ICD-9/-10). With this approach, healthcare leaders can track costs on a per disease/condition basis. Although codes are available for conventional and unconventional healthcare products and services, some healthcare leaders have not yet begun to use these codes to link clinical interventions to ICD codes.[394] Without linking ICD diagnoses codes to interventions, and then linking interventions to payments, healthcare outcomes cannot be traced back to the services and supplies from which they resulted. Healthcare leaders who rely only on ICD coding cannot determine what drives or prevents healthcare inefficiencies. In contrast, leaders in countries and organizations that adopt uniform codes not only for diagnoses, but also for services and supplies, can more easily control the financing and delivery of healthcare. Clearly, ABC codes provide a way to better control the outcomes of CAM interventions and manage healthcare access, quality and cost.

Reliance on ABC codes and other electronic standards allows healthcare payers, hospitals, clinics and practitioners to save money, to improve clinical decision-making, and to generate more favorable outcomes of care.

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Whether for manual or electronic processes, uniformity of standards is essential to healthcare system and organizational efficiency. Chief information and technology officers and their internal customers need ABC codes to streamline data entry, to determine the costs of different approaches to medicine, and to identify those practices that result in the most favorable outcomes.

These codes, used in conjunction with ICD diagnostic codes, provide a way for governments, healthcare insurance companies, provider organizations and practitioners to control escalating healthcare costs and effectively address growing demand for integrative medicine.

Accompanied by RVUs (relative value units), ABC codes also allow for legal and appropriate pricing of healthcare services and supplies. By attaching a value indicator or RVU to each ABC code, healthcare leaders can establish and monitor pricing by diagnosis, service and supply. RVUs establish rational comparative values for CAM interventions. RVUs can be multiplied by euros, yen, pounds, dollars or other international currencies to create a legal and rational price for any CAM intervention in the region where the intervention is provided. That is, the price of any ABC coded service or supply can be set by multiplying the RVU by a conversion factor (CF) that represents a currency amount (e.g., a CF of $5US).

To calculate regional CFs, decision-makers and analysts can divide the regional cost of a known CAM intervention by its relative value. The result will be an estimated CF for the region, useful in establishing a CF for all ABC codes. Using this approach, healthcare financing and delivery organizations can create legal and logical fees for each CAM service or supply. Because rates vary by location, the CF for RVUs may vary but the RVU itself remains fixed. As a result, this pricing system for ABC codes and CAM interventions can be quickly adapted to any region of the world.

By providing uniform standards for clinical communication, value determination and financial transactions, ABC codes and RVUs help healthcare decision-makers make better clinical and administrative decisions, help healthcare organizations and systems save money, and help patients gain access to appropriate care.

ABC codes support evidence-based medicine, which facilitates the natural evolution of healthcare and, ultimately, results in increased health for greater numbers of individuals.

Ideally, healthcare leaders learn continuously, from the practice of medicine, about which healthcare interventions work best. ABC codes and RVUs help governments, insurance companies, provider organizations and practitioners alike *warehouse*, *mine* and *analyze* encounter, diagnosis, treatment and cost data using internal information systems or Internet-based application service providers (ASPs).

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By managing data in this way, these entities can evaluate which interventions generate more favorable outcomes under which circumstances. They can also more effectively manage the financial and clinical resources at their disposal.

ABC codes provide institutional and national solutions to the challenges of improving healthcare accessibility, quality and cost management.

Organizations and nations have long needed a global code set to capture data, develop statistics, and guide decisions about unconventional healthcare interventions. Now, with ABC codes, healthcare entities around the world can share information on nursing and CAM services and supplies to help improve access, quality and cost management.

In addition, by relying on the ABC code developers' scope of practice (SOP) data management capabilities, healthcare leaders can effectively respond to SOP and licensure differences across regions, specialties and interventions.

Nearly every country and organization stands to gain efficiencies and effectiveness from the use of these codes. For example, in the US, an estimated 30% of the $1.2 trillion US annually spent on healthcare results from clinical and administrative inefficiencies,[395] and $30 billion US of this is thought to be a direct result of healthcare transaction inefficiencies.

Precedents for e-commerce enabled savings are well established, for example, in the banking industry (with unified message formats and codes to process bank transactions) and in retail (with universal product codes [UPCs] to facilitate supply chain management). Just as banks save on labor costs for tellers and data entry personnel, and retailers save on labor costs for checkout clerks and inventory managers, healthcare organizations that use uniform code sets for e-commerce save labor on data entry personnel, claims processors, case managers and many other positions. Moreover, these organizations are able to provide ever-increasing quality, supported by outcomes data.

With expertise developed across specialties, geographic and political boundaries, ABC code developers guide practitioners, organizations and political entities in the ongoing integration of nursing and CAM into mainstream healthcare. Developers work closely with payers, providers and academic organizations to ensure CAM interventions comply with healthcare licensing requirements and help reduce the risk of providing or paying for services and supplies that fall outside a practitioner's training or legal SOP.

Three readily available publications offer international thought- and practice-leaders a baseline understanding of ABC codes, RVUs and SOPs:

The CAM and Nursing Coding Manual
Relative Values for CAM and Nursing
The State Legal Guide to Complementary and Alternative Medicine and Nursing (United States)

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One thought- and practice-leader in integrative medicine currently relies on these manuals and has already emerged as an innovator in the academic and clinical application of ABC codes, RVUs and SOPs. Dr. David Riley is board certified in internal medicine, experienced in a variety of CAM modalities, actively involved in clinical research, and the editor of the largest peer reviewed and indexed medical journal of alternative medicine in the world.[396] He has been the principal investigator on a variety of international research projects, conducted randomized placebo controlled clinical trials, managed outcome studies and data collection networks and participated in a variety of regulatory research projects.

Dr. Riley pairs ABC codes with outcome measurement tools to evaluate the most efficient use and mix of western medicine and CAM interventions. This pairing allows for the documentation of details about CAM services and supplies used in treating patients. In turn, this provides him with insight on the care delivered, as well as the resulting economic, health-related quality of life and patient satisfaction outcomes.[397]

Dr. Riley suggests that healthcare leaders can best make use of the results of his and other CAM outcomes studies and randomized controlled trials when these research initiatives accurately document the services delivered. He thinks this is best done using a globally applicable procedure code set accompanied by relative values and legal data. He believes that the CAM code developers' ABC codes, RVUs and SOP data will allow healthcare leaders to improve clinical and financial outcomes, and also facilitate benefit plan development and contracting by linking CAM interventions to practitioner licensure and legal scope of practice. With these uniform standards, he foresees cost-effective integration of nursing and alternative medicine into mainstream healthcare.

For more information on the development and use of ABC codes, RVUs and defining legal use of CAM via SOPs, please contact:

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ALTERNATIVE LINK
Your Coding Company for Integrative Healthcare

Alternative Link's Oral Testimony to NCVHS Subcommittee

(*Note: ABC codes used to be referred to as "ABCcodes."*)

April 10, 2002

Opening Comments

I would like to thank Chairman Cohen and members of the National Committee for Vital and Health Statistics' Standards and Security Subcommittee for inviting me to speak here today about a critical gap in codes for alternative medicine, nursing and other non-MD services. These codes are needed for more than 2.7 million licensed healthcare providers inadequately served by existing HIPAA code sets.

My name is Melinna Giannini. I am the founder and president of Alternative Link and one of the original developers of ABC codes.

ABC codes are 5-characters in length and are followed by a 2-character modifier. Because these codes are the same length as HCPCS level I and II codes, ABC codes fit into existing software applications and healthcare information systems, as well as UB-92 and HCFA/CMS 1500 forms.

ABC codes support non-MDs licensed as healthcare providers in one or more states, who have completed accredited training programs and have met national and state certification requirements.

The code set allows for over 11 million code combinations. It has been market-ready—with databases ready for download and coding manuals in print—since 2001. In fact, the ABCcoding manuals were featured by Delmar/Thomson Learning at this weeks' American Association of Professional Coders convention here in Washington DC. The codes met the approval of every coding professional, software application developer and coding expert who learned of them. They were viewed as "long overdue."

History

ABC codes directly reflect the effectiveness of DHHS in implementing congressional intent under HIPAA. The code set was designed specifically for HIPAA compliance, to address an existing and rapidly expanding gap in coding for alternative medicine, nursing and other non-MD interventions. This gap had already been identified by the National Library of Medicine and was recently reiterated by the White House Commission on Complementary and Alternative Medicine Policy.

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ABC codes deliver the infrastructure needed to determine which alternative medicine, nursing and other non-MD interventions could help manage access, improve healthcare quality and alleviate skyrocketing healthcare costs.

In developing the codes, Alternative Link explicitly followed the guidelines created under HIPAA for code set development and approval--especially those pertaining to administrative simplification and avoidance of billing fraud and abuse. (Please refer to the timeline in our exhibits. We request these exhibits be incorporated by reference into this testimony.)

The code set meets each of the ten guiding principles outlined in the Federal Register/Vol. 63, No. 88/Thursday, May 7, 1998 Proposed Rules. We documented adherence to the guiding principles within the 60-day comment period following that proposed rule. (We are reiterating this in our written testimony to this subcommittee, included in the exhibits.)

Market-ready information products and consulting services are available to support HIPAA covered entities and business associates in implementation of this code set. Among the information products are three publications, some now in their second year of print:

The CAM and Nursing Coding Manual (Delmar/Thomson Learning © 2000, 2001)
The State Legal Guide to CAM and Nursing (Delmar/Thomson Learning © 2001)
Relative Values for CAM and Nursing (Relative Value Studies Incorporated © 2000, 2001)

Alternative Link has already submitted extensive testimony pertaining to the development and acceptance of ABC codes. We have received and followed specific instructions from the DHHS, Designated Standard Maintenance Organizations, ASC X12N, HL7, and EDI experts. (Please refer to the exhibits.)

We have submitted letters of recognition and support from thought- and practice-leading organizations in the healthcare industry. These letters demonstrate that ABC codes address public health and business needs not currently met by code sets adopted under HIPAA. (Please refer to the exhibits.)

The code set supports benefit plan design, utilization management, claims management and appropriate reimbursement. It also facilitates the development of evidence-based practice guidelines through clinical trials, health services research and actuarial analyses. (Please refer to the exhibits.)

ABC codes offer functionality that cannot be achieved by any of the other code sets. This functionality fulfills a unique and essential need of alternative medicine, nursing and other non-MDs. The code set design gives users the ability to link services and supplies to state scope of practice laws for multiple practitioner types. (Please refer to the exhibits and allow us to explain this in greater detail during the question and answer period following our initial remarks.)

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Despite our developing ABC codes within congressional intent, following HIPAA and DHHS requirements, the DSMOs established by DHHS to oversee changes in HIPAA standards have not yet recommended ABC codes be named a standard code set.

Most recently, the DSMOs redirected Alternative Link to approach both the American Medical Association and HCPCS authorities to determine whether ABC codes could somehow be managed as part of HCPCS level I and II codes.

Alternative Link complied with this request even though the AMA had been consistently uncooperative and heavy-handed in past interactions. (Please refer to the exhibits.)

Recently, we have been encouraged by the tone of the AMA's response to our requests to collaborate. At the same time, we remain concerned that collaboration could continue to be difficult and time consuming. For example, within the last month, the AMA encouraged us to apply for CPT codes through the existing code application process without informing us that this would transfer our intellectual property to them without compensation. Also, when we noted this and asked for more specific guidance about how to deal with the particular challenges of addressing ABC codes, they were not able to respond until the day the CPT application was due. Had we not anticipated these responses, we could have lost our ability to represent non-MDs, and our efforts could have been stalled by three more months. As it was, we were able to submit an adapted CPT application within hours of receipt of their guidance letter (on April 4, 2002), and still retain rights to develop the codes and the rights of non-MD providers to an unbiased review process.

Our adapted CPT application points out the unique and essential functionality of ABC codes, as well as the extent of code set development (i.e., the existence of about 4,000 service and supply descriptors and corresponding legal scope of practice information and relative value units). It asks the AMA to either 1) acknowledge the differences in code set functionality and recommend ABC codes be named a separate standard or 2) propose a way to accommodate the codes and serve the needs of non-MDs. Given the AMA's encouraging tone, we remain hopeful.

In relation to adding ABC codes to HCPCS level II, we received the support of Kaye Riley, the Director of the HCPCS Panel. (Please refer to the exhibits.)

Where We Are Today

Unlike allopathic physicians, alternative medicine, nursing and other non-MD providers are governed by different laws in each state.

While the AMA CPT Editorial Panel is expert in coding conventional medicine, it does not have expertise in coding alternative medicine, nursing or other non-MD interventions. If it did, it would already have developed thousands of codes comparable to ABC codes. Instead, only a handful of non-specific codes have been developed.

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For this reason, claims for non-MD interventions often need to be manually processed or supplemented by extra paperwork to document treatment rationale. In relation to non-MD interventions, CPT codes do not meet congressional intent vis-à-vis HIPAA.

Legal experts realize that no two states have the same laws regarding alternative medicine, nursing and other non-MD providers. To our knowledge, Alternative Link is the only organization that has built this type of information into coding functionality on a code-by-code, state-by-state and provider-by-provider basis. Thus, the entire domestic healthcare industry needs ABC codes in their present form.

We have analyzed overlaps with CPT and found less than a 10% crosswalk. Our code set maintenance process is impartial. Applications may be submitted by anyone. Code development, approval and obsolescence are overseen by independent coding administrators based on written procedures and formal standards, with systematic reviews by training, licensing and other authorities. These procedures and standards are described in coding publications and on the Alternative Link website. The code set is updated continually. New releases of the codes are issued annually. Adoption by payers is forthcoming, upon naming as a code set standard. Coding manuals include general guidelines for coding, as well as expanded definitions for each procedure to avoid confusion over the appropriate use of those codes. Expanded definitions are available in both electronic and hard copy formats. Current users adhere to guidelines and have not needed to develop their own definitions. Updates are disseminated by Alternative Link and its distribution partners (e.g., Delmar/Thomson Learning and Relative Value Studies, Incorporated). ABC codes are available for $49.95 as an ASCII flat file and for $59.95 for a PDF coding manual. State code reports for each provider in each state are available for $19.95 per report. The codes are available in both hard copy and electronic formats. The licensing fee structure is comparable to the fee structures established for existing code sets.

Conclusion

In summary, ABC codes fill critical gaps in coding, support congressional intent and include intelligence that current HIPAA code sets and the proposed ICD-10 were not designed to provide.

Should the NCVHS decide on a single national code set in the future, Alternative Link will map ABC codes and modifiers to the new national standard.

In the meantime, Alternative Links pleads with NCVHS to make a decision pertaining to ABC codes today. ABC codes will provide critical information urgently needed for benefit plan design, utilization management, claims management and appropriate reimbursement, as well as health services research, actuarial analyses and outcomes research.

The industry needs the code set now.

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Alternative Link's Oral Testimony to NCVHS Subcommittee
(*Note: ABC codes used to be referred to as "ABCcodes."*)
May 30, 2002

Opening Comments

Good morning, Mr. Chairman, members of the National Committee on Vital and Health Statistics' Standards and Security Subcommittee (NCVHS/Subcommittee) and others here today.

Alternative Link appreciates the invitation to report on recent interactions with the American Medical Association (AMA). These interactions were mandated by the Designated Standard Maintenance Organizations (DSMOs) and the Subcommittee, and facilitated by a staff member of the Centers for Medicare and Medicaid Services (CMS).

Our understanding from the April 10th public hearing and, especially, from a separate meeting with NCVHS staff, CMS staff and the AMA later that day, was that this mandate had two distinct elements. The AMA was to:

review the functionality and value of the market-ready ABC codes and establish a business agreement on a mutually acceptable approach to the situation and any relevant intellectual property issues; and,

on the basis of that business agreement, collaborate to integrate the functionality of ABC codes and CPT codes in a manner that supports public health, health industry business needs and congressional intent under HIPAA.

During this testimony, Alternative Link will:

describe the challenges of trying to collaborate with the American Medical Association, even with expert facilitation by Subcommittee and CMS staff;

review the AMA's mixed history of public health achievements and political behavior;

stress the urgency of the code set situation, emphasize the life-saving potential of the ABC codes and report on the hundreds of thousands of human lives that could be lost as a result of further delays in code set availability;

highlight benefits and functionality offered by ABC codes for alternative medicine, nursing and other non-MD interventions; and

use an analogy from the grocery industry to illustrate why stakeholders benefiting from an existing supply chain infrastructure should not have control over coding for new technologies.

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Recent Experience with the AMA

Alternative Link found the AMA to be unreliable, self-serving and predatory in its approach to the mandated collaboration.

The AMA's newly proposed alternative therapies CPT coding initiative establishes the AMA as a direct competitor to, rather than a collaborator with, Alternative Link.

Although the AMA may—at this point in time—have some legitimate intentions in the monopolistic role it is proposing for itself, this stance will also position the AMA to:

delay code set availability and keep alternative medicine, nursing and other non-allopathic physician practitioners disenfranchised from mainstream healthcare;

manipulate code assignment to make difficult head-to-head scientific comparisons of conventional/physician and unconventional/non-MD interventions;

reverse engineer Alternative Link's intellectual property; and

enhance the political strength of allopathic physicians by dominating a critical element of the healthcare infrastructure.

In our view, the DSMOs, the NCVHS Subcommittee and the DHHS as a whole did not intend to give the AMA the authority to behave as a monopoly. The AMA's monopolistic stance is, however, an unfortunate byproduct of the mandate to collaborate. This is particularly disturbing because DSMO and Subcommittee leadership assured Alternative Link that DHHS believed the AMA would be more collaborative than it had been in past interactions. We were told that the AMA had been counseled to be cooperative, transparent, impartial and socially responsible—clear duties of a designated standard.

In a separate meeting on April 10th (following the Subcommittee's directive to the AMA and Alternative Link to try to work together), Subcommittee and CMS staff advised the AMA to address two things in collaborating with Alternative Link:

First, seriously consider the immediate functionality and value of the 4,000 market-ready ABC codes and—depending on the significance of these codes to public health, health industry business needs and congressional intent under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)— come to an agreement about how best to make use of the codes, and establish an appropriate business relationship, including an acceptable approach to any relevant intellectual property issues.

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Second, with code set merits and intellectual property issues settled, collaborate on a code set integration processes that serves public health, business needs and congressional intent under HIPAA.

The AMA agreed to follow this directive.

Based on the DSMO and Subcommittee assurances—as well as the AMA's own statements about their new leadership and collaborative approach to the industry—Alternative Link laid aside a long history of negative experiences with the AMA and agreed to collaborate with "a new and improved AMA."

In the past six weeks—in marked contrast to its presentation in the April 10th hearing and its commitments in the separate meeting that followed—the AMA exhibited aggressive competitive behavior.

In particular, the AMA:

withheld a non-disclosure agreement it agreed to generate that would have facilitated more meaningful discussions about the market-ready ABC codes and their ability to contribute to public health, address health industry business needs and satisfy congressional intent under the HIPAA;

proposed a crosswalk from ABC codes to CPT codes—something it had obstructed in prior years—and asked Alternative Link to refocus our business on claims edit/scrub applications.[398]

showed virtually no interest in examining the characteristics, development and maintenance process, functionality and/or value of the ABC codes, and then argued that no basis existed for a code integration-related business relationship or an intellectual property agreement;

canceled two meetings that were jointly scheduled on April 10th, the first one scheduled for May 1st and intended to cover intellectual property, and the second scheduled for May 14th and intended to cover code set integration processes; and

when Alternative Link reminded the AMA of its commitment to first address business and intellectual property issues, flatly stated that the AMA would establish an Alternative Therapies Workgroup and develop competitive CPT codes with or without Alternative Link's involvement.

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Disregarding its duty and pledge to be a cooperative, transparent, impartial and socially responsible code set authority, the AMA is now in a position to:

delay code set availability and keep unconventional/non-MDs disenfranchised,

manipulate code assignement,

reverse engineer Alternative Link's intellectual property, and

use a critical component of the healthcare infrastructure to exercise a monopoly and advance allopathic physician interests.

The AMA's History Prior to the DSMO and Subcommittee Directives

From its inception in the mid-1800s, the AMA has protected physician interests both legitimately—by supporting meaningful public health initiatives—and illegitimately—by suppressing potentially competitive providers under the guise of protecting public health.

While the AMA has undertaken many inspiring public health initiatives, it is undeniably a political organization:

1849: AMA establishes a board to analyze quack remedies and nostrums and to enlighten the public in regard to the nature and dangerous tendencies of such remedies.

1925: AMA Propaganda Department becomes Bureau of Investigation.

1943: AMA opens office in Washington DC. AMA Council on Medical Service and Public Relations is established.

1948: AMA launches a campaign against President Truman's plan for national health insurance.

1961: The American Medical Political Action Committee (AMPAC) is formed to represent physicians'… interests in health care legislation.

1966: AMA publishes first edition of the Current Procedural Terminology (CPT), a system of standardized terms for medical procedures used to facilitate documentation.

1983: AMA and the Health Care Financing Administration (HCFA, now CMS) sign an agreement requiring the use of CPT in federal programs for the reporting of physicians' services, as part of the administration's common procedural coding system (HCPCS). Subsequently, HCFA in 1986 extended the requirement to state medical agencies using the Medicaid Management Information System.

1991: AMA proposes reform of the U. S. health care system (Health Access America) to include expansion of health insurance coverage.

1995: AMA encourages Office of Alternative Medicine of the National Institutes of Health to evaluate the safety and effectiveness of alternative therapies.

1998: The AMA… implement(s) an aggressive campaign to bring needed changes to HCFA's revised Documentation Guidelines for Medicare Evaluation and Management Services. This campaign include(s) web-based information for physicians and aimed at protecting them from unwarranted fraud and abuse penalties.

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1999: Addressing the national trend toward consolidation among large health insurance and health care providers, the AMA increase(s) its advocacy efforts, ensuring the protection of U.S. physicians and their patients.

2000: In an effort to help physicians provide the most trusted and comprehensive resource for health care information to their patients on the Internet, the AMA, in partnership with six of the nation's leading medical societies, implemented its newly created electronic health network, Medem.(www.medem.com)[399]

The AMA's commitment to its allopathic physician membership is common knowledge in the healthcare industry and is referred to on the AMA's own website:

"The AMA is much more than an organization of physicians. We are …the physician's voice[400]*… the nation's most influential medical organization*[401]*…the leading advocate for physicians."*[402]

With only a few "bad apples" deviating from a largely civic-minded mission, a trade association that serves allopathic physicians and is a designated code set authority could easily withhold, or continue to introduce biases into, code development:

to limit the scientific collection and analysis of healthcare data needed for head-to-head quality and cost comparisons between conventional/physician and unconventional/non-MD interventions; and

to restrict public access to unconventional/non-MD interventions.

Alternative Link recognizes that the AMA's Board of Trustees is committed to "the art and science of medicine and the betterment of public health."[403]

That notwithstanding, the AMA itself has expressed proprietary interest in maintaining control over coding of allopathic care and gaining greater control over the coding of alternative medicine, nursing and other non-allopathic physician interventions.

For example, in a presentation to the AMA Board of Trustees on December 4, 2000, the AMA Board Chair[404] stated,

"*You may have never realized the huge investment physicians have in (coding)—not in terms of dollars—but an investment in physician autonomy… AMA administration of a physician-driven process… (coding) has given…(us)…a cohesive voice in… health care delivery—a voice that makes us stronger and louder than we are as individuals... In an age where physician autonomy is in danger of slowly being chipped away, how did the AMA secure a physician-driven standard used to describe medical services, not only for payers, but also for all of the health care industry? … Certainly, physician control of a uniform code has not always been the norm."*

The AMA is a politically astute organization. Its members are politically active and strategically placed.

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The AMA has been well represented on the DSMOs (with the AMA permanently chairing one of the DSMOs, the National Uniform Claims Committee, and holding a seat on the National Uniform Billing Committee).

Conventional allopathic physicians have been serving in DHHS and on the NCVHS Subcommittee.

Conventional allopathic physicians are also in leadership positions in the Health Insurance Association of America (HIAA) and other organizations with significant influence in code development and maintenance.

With this level of advocacy, the AMA has maintained a position of control over this critical component of the healthcare infrastructure, despite well-known weaknesses in the CPT code set and the CPT Editorial Process. (As early as 1993, the NCVHS reported that the AMA's code development process was flawed and was widely believed to favor AMA membership. That notwithstanding, the AMA's CPT code set was named a designated standard under HIPAA.)

The AMA CPT Editorial Panel is almost exclusively conventional medical doctors, as is the CPT Advisory Committee. (Please refer to CPT 2002, p. iv.) The Health Care Professionals Advisory Committee (HCPAC) and the newly formed Alternative Therapies Workgroup include some other practitioners, but both fail to include more than 90 specialty associations (not including over 50 specialties of nursing). Despite the advisory bodies within the AMA, final decisions are still made by a decision making body that is almost exclusively allopathic physicians.

While AMA leadership includes some individuals who are clearly committed to cooperative, transparent, impartial and socially responsible coding, the AMA in practice has not lived up to the laudable goals put forth by the Board of Trustees. For example, as a coding innovator for alternative medicine, nursing and other non-MD interventions, Alternative Link has repeatedly approached the AMA in a spirit of collaboration.

In doing so, Alternative Link has documented five years of contentious behavior by the AMA. This behavior has delayed and reduced the healthcare industry's ability to design insurance benefit plans, manage utilization and process claims, as well as manage clinical trials, conduct health services research and perform actuarial analyses. Worse, as we will describe, it has cost thousands of lives.

Our intention *is not* to vilify the AMA. The AMA has supported some of the greatest public health initiatives this country has ever known. Our intention *is* to say that—even under the best of circumstances—a political organization with an allopathic physician agenda will be hard-pressed to divorce itself from self-interest and demonstrate cooperative, transparent, impartial, and socially responsible behavior in code development for alternative medicine, nursing and other non-allopathic physician interventions.

In this particular area, the AMA's record has been less than stellar—a great shame given the impressive history of the organization.

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We ask that the Subcommittee please refer to Alternative Link's "HIPAA-Compliant Code Set Development Timeline" and to the recent chronology of AMA and Alternative Link communications to understand the dangers of putting coding for alternative medicine, nursing and other non-MD interventions into the hands of the AMA, with its ongoing pattern of behavior.

Urgency, Life Saving Potential and Possible Death Toll

According to the Journal of the American Medical Association (JAMA), over 100,000 patients die in the U.S. each year as a direct result of hospital and physician errors and not the diseases for which these citizens sought treatment. That number again die from negative effects of "appropriate" conventional treatments.[405] In total, nearly a quarter of a million individuals die from iatrogenic causes, including an estimated 12,000 from unnecessary surgery, 7,000 from medication errors in hospitals, 20,000 from other errors in hospitals, 80,000 from infections in hospitals and 106,000 from non-error, negative effects of drugs.[406]

For this and many other reasons, American citizens are increasingly turning to alternative medicine, nursing and other non-allopathic physician interventions as a primary source of care. In fact, according to subject matter experts, complementary and alternative medicine (CAM) has a compounded annual growth rate of 38% and more visits are made each year to CAM practitioners than to primary care practitioners (PCPs).[407]

Imagine the chaos that would exist in the industry today if the practices of PCPs were uncoded. PCPs would essentially be disenfranchised from mainstream healthcare. That is exactly the situation with alternative medicine, nursing and other non-allopathic physician practitioners.

If the AMA were granted coding authority over alternative medicine, nursing and other non-allopathic physician interventions, public health would suffer tremendously.

Three reasonably probable scenarios (based on the JAMA statistics) make this clear:

Scenario #1. The AMA is politically motivated in the development of codes for unconventional/non-MD interventions. Codes are defined with insufficient granularity or interventions are intentionally bundled and coded is such a way as to preclude the demonstration of superior outcomes for alternative medicine, nursing and other non-allopathic physician interventions when compared head-to-head with conventional interventions.

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Suboptimal care patterns result in a 10% increase in unnecessary hospitalizations, physician visits and other types of conventional care. The setback in actuarial capabilities costs no fewer than 320,000 lives[408]—more than 100 times the number of lives lost in the 9/11 attacks.

Scenario #2. The AMA is politically divided over the development of unconventional/non-MD interventions and code development stalls out. ABC codes are named a standard code set in 2010 instead of 2002.

The setback in code set availability could cost 160,000 lives[409]—more than 50 times the number of lives lost in the 9/11 attacks.

Scenario #3. The AMA wholeheartedly embraces the need for unconventional/non-MD codes and relies on the existing CPT Editorial Process—plus an Alternative Therapies Workgroup—to generate a remarkable 250 to 500 new codes per year. Assuming the AMA would somehow avoid violating Alternative Link copyrights and patents, the AMA would take no fewer than 8 years to achieve what Alternative Link has already completed.

If the coded unconventional/non-MD interventions could have prevented 10% of unnecessary hospitalizations, physician interventions and other forms of conventional care, more than 20,000 lives per year—nearly 55 per day—would be unnecessarily lost due to conventional treatment errors and known side effects of treatment.[410]

Under the most favorable circumstances, with no fewer than 500 codes developed per year, by 2010, this setback in code set availability could cost 90,000 American lives[411]—more than 30 times the number of lives lost in the World Trade Center and Pentagon attacks.

Assuming that 10% of conventional care would be made unnecessary by unconventional/non-MD care, every two-month delay in making the functionality of ABC codes available to the industry costs more lives than were lost in last year's terrorist attacks.[412] Similarly, a 10% displacement of potentially harmful unconventional/non-MD interventions by safe and effective conventional allopathic physician care could save a comparable number of lives every two months.

The point is that the functionality of ABC codes is needed *immediately* to support cost-effective, evidence-based and integrative healthcare. The cost of delays is staggering in terms of potential loss of human lives. If we also consider the dollars wasted as a result of unnecessary administrative inefficiencies—dollars that could be reallocated to generate greater prosperity or to cover the uninsured—the human toll is even more devastating.

The Benefits and Functionality of ABC codes and Ways to Make Them Accessible

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To make possible the *responsible* integration of unconventional/non-MDs into mainstream healthcare, the founder and research team at Alternative Link spent seven years and millions of dollars eliciting expert support, with their assistance, developing approximately 4,000 market-ready codes for 13 categories of alternative medicine, nursing and other non-allopathic physician interventions.

These codes were systematically developed and are maintained in collaboration with subject matter experts, academic institutions, trade associations, licensing boards and government entities. They offer hierarchic design features and alphabetic characters that allow for more than 11 million code combinations, plus greater functionality and expandability than CPT codes. In fact, ABC codes are sufficiently robust to resolve many of the code set challenges of the healthcare industry.

In 1998, at the government's request, ABC codes were added to the National Library of Medicine's Unified Medical Language System. Today, these market-ready and ANSI ASC X12N-compliant codes are supported by detailed information that identifies who can do what in each of the 50 United States and the District of Columbia. For each code, this supporting information includes 1) practitioner training requirements; 2) state statutes, administrative regulations and case law; and 3) relative value units.

The supporting information is housed in a market-ready database that includes over 13 million units of information for accurate adjudication of claims under HIPAA, as well as numerous other essential health industry research and business processes. The contents of the database are publicly available in three publications already on the market through Delmar/Thomson Learning and Relative Value Studies, Inc.:[413]

The CAM and Nursing Coding Manual

The State Legal Guide to CAM and Nursing

Relative Values for CAM and Nursing

Interestingly, in the time Alternative Link developed 4,000 market-ready unconventional/non-MD codes and supporting scope of practice and relative value information urgently needed by the healthcare industry, the AMA developed only two codes for acupuncture and four codes for chiropractic services—these prompted by legal action.

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A Coding Analogy from the Grocery Industry

Sometimes, to get a clear picture of a situation, we need get out of the details and just hear things put simply—in a way that everyone can understand. Alternative Link believes an analogy from the grocery industry would make the point that a coding decision should not be held hostage in a political battle—especially when that battle could compromise public health, industry efficiencies and compliance with legislative intent.

We are all familiar with Universal Product Codes, called UPCs. They are placed on retail products, such as your groceries, not only to allow for scanning at check out, but also to support efficiency of the entire supply chain, from manufacturing through wholesale and retail distribution.

Just as a UPC on a package of Kraft cheddar cheese does not force a retailer to carry that brand in his store, an ABC code or a CPT code assigned to a complementary healthcare intervention does not force a health plan to offer that intervention as a benefit. It simply allows that intervention to be tracked and managed.

Kraft cheddar cheese requires refrigeration, as do most conventional dairy products. It can be thought to represent a conventional offering in the marketplace.

Now, imagine that a European company developed a new technology that made possible the production and packaging of dairy products that could be stored at room temperature. Imagine if this technology supported twice the shelf life of conventional dairy products and delivered a better tasting product.

Imagine that a few innovative US dairy farmers started using the new European technology to process dairy products and began to test these products in local stores and farmers markets. Imagine that, in these test markets, demand for the innovative dairy products surged because retailers and customers preferred not to have to restock their supplies as frequently and were also grappling with skyrocketing energy bills resulting from excessive use of electricity and transportation fuels.

Imagine that the innovative dairy farmers were interested in supplying the dairy products on a national basis, through major retail chains—some of whom had already started to sell the products on a trial basis. Imagine that, in order to support an efficient supply chain and satisfy growing demand from retailers and consumers, the farmers needed the Uniform Code Council to assign this new class of dairy products hundreds of unique UPCs.

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Imagine that the conventional dairy product producers, distributors and vendors had invested considerable capital in the existing infrastructure for refrigerated dairy products and refrigerated transportation (e.g., in refrigeration equipment and supplies). Imagine, too, that these stakeholders derived considerable revenues from these sources and did not have an equity stake in the new dairy products.

Imagine that these conventional stakeholders first initiated a political campaign and a negative advertising campaign against the new dairy products, implying that the products were a health hazard. Imagine that demand continued to surge.

Imagine that the conventional stakeholders then initiated a series of legal actions that distracted the dairy product innovators from their innovative product development activities. Imagine that the innovators somehow managed to stay in business and continue to supply their customers.

Imagine that the conventional stakeholders then tried to take over the Uniform Code Council so they could control whether and how codes would be issued for the innovative dairy products.

Worse, imagine if the conventional stakeholders were named as the Uniform Code Council by the government.

Imagine that issuance of the UPC codes supported political agendas rather than the public good.

Without UPCs, innovative dairy product manufacturers would be unable to accurately forecast demand to support production, inventory and distribution planning. Dairy product retailers would be unable to forecast sales, efficiently stock shelves and purchase products electronically.

Dairy industry associations and dairy research organizations would be unable to track spoilage and determine scientifically the extent to which the new dairy products extend shelf lives, offer cost savings and do a better job of meeting consumer needs.

Conclusion

As suggested by the above analogy, medical codes are to the healthcare industry what universal product codes (UPCs) are to the retail industry. That is, codes are a vital part of the industry's infrastructure. They support electronic communications and transactions that are essential to proper functioning of the industry. However, unlike UPCs in retail, codes in healthcare do a great deal more than support the industry's supply chain. In healthcare, codes enable industry stakeholders to control healthcare access, quality and costs, and to manage care, claims and outcomes. Because of this, delayed and/or improper development, management and use of codes can result in lost lives.

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As the section entitled, "Urgency, Life Saving Potential and Possible Death Toll" makes clear, this code set authority issue is one of the most critical health data issues facing the nation. The NCVHS Subcommittee's recommendation to the Secretary of DHHS, regarding ABC codes, will impact public health for years to come. The Subcommittee will help the Secretary decide whether the AMA (a trade association which represents allopathic physicians) will control a vital component of the healthcare infrastructure and thereby gain the ability to control public access to interventions offered by other healthcare practitioners—even if those interventions offer better economic and health outcomes. This is roughly akin to giving GM control over Ford parts and service…but it affects human lives, not automobiles.

ABC codes are urgently needed to design healthcare insurance benefits, manage utilization and process claims, as well as run clinical trials, conduct health services research and perform actuarial analyses.

With regard to public health, about a quarter of a million Americans die from iatrogenic causes related to conventional approaches to healthcare.[414] Unconventional/non-MD approaches to healthcare are typically more preventive and less invasive than is allopathic physician care. Preventing diseases and thereby avoiding hospitalizations and drug interventions saves lives, but those who earn their living by treating diseases may not perceive it as "good business."

Some alternative medicine, nursing and other non-allopathic physician interventions are effective and some are not. Some may displace conventional allopathic physician interventions and some may be quackery. The challenge is that the scientific evaluation of these unconventional/non-MD interventions is currently limited, since the AMA, in more than 30 years of code development, has all but ignored these approaches to healthcare. In the same period of time, the AMA has coded thousands and thousands of allopathic physician interventions.

The AMA is proposing to control tools that are essential for scientific research, as well as the management of care, the processing of medical insurance claims and the assessment of economic and health outcomes.

Concern about the AMA's proposal is widespread and yet the industry's outcry has been preempted by widespread fear of AMA retaliation.

Alternative Link has been told by leading conventional and unconventional practitioners, academic research institutions, trade associations and payers that they applaud our work and want our codes to become a designated standard.

At the same time, we have been asked by many of them to keep their identities hidden. Why? Because they view the AMA as a powerful monopoly that will take retaliatory action against them.

Practitioners fear a loss of referrals.

Academics fear their articles will be banned from JAMA and other medical publications.

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Trade associations fear the limited progress they have made in years of negotiations with the AMA will be lost.

Payers fear they will have difficulty with their provider contracts.

Because our livelihood depends largely on ABC codes, we are in the unenviable position of being David against the AMA's Goliath.

However, unlike David, our motivation has not been to destroy the giant. Instead, we have tried for years to collaborate with the AMA. When that did not work, we tried to avoid their attacks. When the government directed us to face them again, we set aside our concerns and approached the issue in a cooperative, transparent, impartial and socially responsible manner.

We have not insisted that our code set be incorporated into the CPT codes, although we believe this is one of many potential solutions. In fact, our CPT application was prompted by the AMA, not conceived by us.

Instead, as requested by the DSMOs and Subcommittee, we have repeatedly asked the AMA to evaluate the functionality and merits of the ABC codes as a whole and—depending on the significance of these codes to public health, health industry business needs and congressional intent under the HIPAA—establish a business agreement.

We have suggested that, on the basis of that business agreement, we could collaborate to integrate the functionality of ABC codes and CPT codes in a manner that supports public health, health industry business needs and congressional intent under HIPAA.

We have encountered insurmountable challenges with the AMA in the past six weeks, and the past five years.

The market urgently needs codes for alternative medicine, nursing and other non-allopathic physician interventions.

ABC codes meet public health and business needs, and comply with congressional intent under HIPAA.

ABC codes offer a market-ready solution that will increase the industry's ability to promote cost-effective, evidence-based and integrative healthcare.

ABC codes have the potential to save hundreds of thousands of lives per year.

With human lives at stake and an industry burdened by expenditures for scientifically unsubstantiated care, a coding decision should not be held hostage in a political battle over public access to unconventional/non-MD care.

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If the AMA gains Subcommittee endorsement in coding alternative medicine, nursing and other non-allopathic physician interventions, it will have a monopoly over a critical component of the healthcare infrastructure. From this position, it will be able to restrain trade, compromise public health, exacerbate inefficiencies in the cost-burdened healthcare industry and violate congressional intent under HIPAA.

In contrast, implementation of market-ready unconventional/non-MD codes will quickly separate quackery from meaningful medical interventions. It will put decisions about healthcare access back into the hands of the people, their government representatives, and the healthcare providers and insurers they select. This will ultimately support greater consumer choice, as well as more cost-effective, evidence-based and integrative healthcare.

Despite the AMA's aggressive competitive stance, in our most recent communication with the AMA, we reiterated the benefits of a collaborative approach. We continue to believe we can help the AMA in:

Taking an impartial approach to code development and maintenance that could reverse public, industry and legislature perceptions of trade association bias;

Protecting its franchise in allopathic physician code development and maintenance, while improving its relationship with alternative medicine, nursing and other non-MDs;

Improving its product by gaining access to a hierarchic code structure and improved code set functionality that better support cost-effective, evidence-based and integrative healthcare;

Increasing its revenues by jointly expanding the market for code set licenses and publications; and

Reducing costs by reengineering its business processes based on a systematic review and appropriate adoption of ALI's best code development and maintenance practices.

Our goal has always been to use ABC codes and supporting tools to bring cost-effective, evidence-based and integrative healthcare into the mainstream, and thereby support the health and welfare of the public.

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In 1999, Alternative Link established a non-profit organization to reinforce an already cooperative, transparent, impartial and socially responsible approach to code development and maintenance. The structure of the organization has been established and includes subject matter experts, academic organizations, trade associations, key categories of health industry stakeholders and government representatives. The non-profit is ready to assume authority for ongoing code development and maintenance.

Public demand for alternative medicine, nursing and other non-allopathic interventions continues to escalate. The industry needs a code set now to help manage care, claims and outcomes for unconventional/non-MD interventions. In light of this, Alternative Link asks that the Subcommittee carefully review the ABC codes and, upon confirming their value, recommend them as a designation standard.

We ask for your help in supporting the Secretary of DHHS in making a rational decision based on public health interests, critical industry needs and congressional intent under HIPAA.

Details of Interactions with the AMA

Despite this, the DSMOs had not only issued the mandate, but had also begun to make derogatory public statements about Alternative Link, implying that Alternative Link was being somehow uncooperative. The organizers of a West Coast conference on HIPAA compliance professionally recorded at least one such statement.

Between March 13th and April 10th, despite an encouraging tone in the discussions with the AMA, Alternative Link became aware that the AMA wanted to reverse engineer Alternative Link's intellectual property for the AMA's proprietary benefit.

In our April 10th testimony to the Subcommittee, Alternative Link reported serious concern that the AMA collaboration could continue to be difficult and time consuming.

Alternative Link noted that the AMA had encouraged Alternative Link to apply for CPT codes through the existing code application process without informing Alternative Link that this would transfer Alternative Link's intellectual property to the AMA without compensation.

Alternative Link also reported that the AMA had delayed providing guidance about how to address application related challenges until the day the CPT application was due.

Alternative Link noted that—had we not anticipated these responses—we could have lost our ability to represent alternative medicine, nursing and other non-MDs, and our HIPAA compliance efforts could have been stalled by three more months.

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Following our April 10th testimony—despite our candid comments about the challenges of working with the AMA—the Subcommittee directed us to continue communications with the AMA and continue to try to integrate the two code sets.

In a separate meeting following the April 10th testimony, a group of DHHS staff members met with Alternative Link and the AMA, expressed concern that another six weeks might pass with no progress made on the collaboration and offered to facilitate meetings and discussions to assure the most positive outcome possible.

In that meeting, with DHHS guidance, the AMA made special note of a change in the AMA's top leadership that would facilitate a collaboration and expressed a commitment to this end. In addition, the AMA agreed to 1) draft a mutual non-disclosure/non-compete agreement typical of joint-ventures and alluded to skills in protecting intellectual property; 2) execute the non-disclosure/non-compete agreement prior to May 1st; 3) meet on May 1st to resolve intellectual property issues and come to a mutually satisfactory arrangement for moving forward with code set integration planning; and 4) meet on May 14th to initiate code set integration planning.

Alternative Link wrote an email to the AMA shortly following this separate meeting and asked for the non-disclosure agreement, as well as an early sense of the direction the AMA planned to take on business discussions.

In a subsequent telephone call, facilitated by Stanley Nachimson of CMS, without alluding to any review of ABC codes, the AMA said that the AMA did not recognize the value of ABC codes and other Alternative Link intellectual property. The AMA referred to ABC codes as "ideas" and said that the CPT Editorial Process was government-endorsed and more legitimate than Alternative Link's code development process. The AMA said that—rather than discuss Alternative Link's intellectual property any further—the AMA would establish an Alternative Therapies Workgroup to evaluate the need for CPT codes for alternative medicine. The AMA reiterated this position in a subsequent letter and, in a subsequent email, cancelled the intellectual property meeting of May 1st.

Alternative Link responded to the AMA by asking the AMA to 1) assess ABC codes before taking any position on the code set's merit or value relative to CPT codes; 2) clarify its position relative to several direct questions; and 3) raise the level of discussion to ensure public health, business and HIPAA-related needs would be met by the code set integration solution. We referred directly to the need to comply with the guidance provided by the NCVHS regarding an initial review of intellectual property and a subsequent discussion of code set integration processes.

The AMA responded with an email that ignored Alternative Link's direct questions, implied that Alternative Link was being uncooperative vis-à-vis the proposed workgroup, and noted that the AMA was moving forward with the Alternative Therapies Workgroup with or without Alternative Link's involvement. In this communication, the AMA cancelled the code set integration planning meeting that had been scheduled for May 14th.

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Alternative Link responded by emphasizing Alternative Link's desire to cooperate and reiterating the need to comply with NCVHS/CMS instructions and raise the level of discussion to address immediate public health and business needs, as well as congressional intent under HIPAA.

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EXHIBIT U –DATA ON BACK PAIN DISORDERS FROM A FORTUNE 200 COMPANY SUPPORTS THE VALUE OF ABC CODES

MediMerge Health
A MediMerge Group Company

Comparison of Data Capture for Back Pain Disorders - CPT Codes vs ABC Codes

Check	E&M Modifier	Component	Detail Captured by Selected CPT Coding	Detail Captured by ABC Coding	ABC Code Range
Conventional	1M	Initial exam	yes	yes	Primary area ABC for detailed evaluation and diagnosis
		X-ray	yes	yes	ADYAB
		MRI	yes	yes	DHAAA
		CT scan	yes	yes	
		EKG analysis	yes	yes	
		Pain	no	1	
		PT	yes	yes	
		Blood test Panel	no	2	
		Meds RX	no	4	
		Pain medication	no, meds be covered from chronic dx	no, meds be covered from chronic dx	
		Follow up exam	yes	yes	Primary area ABC for detailed evaluation and diagnosis
Massage, Bodywork,	1B	Initial exam	no, coding will support duration of PT, physical medicine only, but will not be no chance on seeing medicines, all detail is lost	yes, ABC codes allow for tracking of each modality, detail is retained for analysis of outcomes	Primary area ABC for detailed evaluation and diagnosis
		Therapeutic massage	no	yes	CBBAB - CBBII
		Clinical massage Shiatsu	no	yes	CBCAA - CBCII
		Bodywork, process specialties	no	yes	CBBAA - CBBII
		Energy work, process specialties	no	yes	CBDAA - CBDII
		Ergonomics, process specialties	no	yes	CBEAA - CBEII
Chiropractic	1A	Initial exam	yes	yes	Primary area ABC for detailed evaluation and diagnosis
		Adjustments	no, very limited code set	yes, with extensive detail	CCAAA - CCEII
		Manipulation	no	yes	CCBAA - CCBCD
Clinical Nutrition	IE	Initial, medical interview			Primary area ABC for detailed evaluation and diagnosis
		Nutraceuticals	no	yes	CCBAA - CCBCD
Biomedical Medicine	dd	Initial, medical interview			Primary area ABC for detailed evaluation and diagnosis
Acupuncture & Oriental Medicine	1C	Initial exam	yes	yes	Primary area ABC for detailed evaluation and diagnosis
		Acupuncture procedures	yes, generally bundled, one code for visit and without electrical stimulation	should be coding of Primary procedures, with electrical stimulation, therapies, and use in practice.	CABAB - CABBY
		Acupuncture supplies	no	yes	BAAAB
		TCM preparations	no	yes	CAAAA - CAIII
		Herbal remedies	no	yes	CBAAA - CBIII / CEAAA - CFIIY
Homeopathy	IL	Initial exam	yes - bundled code for the specialty providing history and consultation	yes - bundled code for the specialty providing history and consultation	Primary area ABC for detailed evaluation and diagnosis
		Specific preparations	no	yes	HAAAA - HAIII
Neuropathy	1B	Initial exam	yes	yes	Primary area ABC for detailed evaluation and diagnosis
		Manipulation	no	yes	CBBAA - CBBII
		Nutraceuticals	no	yes	CCBAA - CCBCD
		Other services	no	yes	CBCAA - CBCII
Osteopathic Medicine	1L	Initial exam	yes	yes	Primary area ABC for detailed evaluation and diagnosis
		Manipulation	no	yes	CCAAA - CCAII
		Other services	no	yes	CCBII
		Nutraceuticals	no	yes	CCBAA - CCBCD
Physical Medicine	dd	Initial exam	yes	yes	Primary area ABC for detailed evaluation and diagnosis
		Manipulations	yes	yes	
Chinese Science	1S, 1T	Initial exam	yes	yes	Primary area ABC for detailed evaluation and diagnosis
		Consultation detail	no	yes	CIAAA - CIABW

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ABC Codes Led to More Cost-Effective Treatment Guideways for Key Diagnoses

Guideway Description

- Over time, the various conditions that comprise this group of disorders are costly to treat due to the need for frequent medical supervision, possible complex surgeries with associated hospital costs, and the large amount of medications necessary to manage the conditions. These conditions can be a major impairment to daily function and one or more of the conditions effects approximately 60% of the population at some point in their lives
- The guideway establishes a blueprint for the MediMerge Health Advocate Intervention Process in dealing with patients exhibiting these conditions
- The process assists the Health Advocates in providing a clinically appropriate response and action plan to improve the treatment of an individual with this condition and assist in making appropriate lifestyle changes that can improve the quality of life
- An individual with a chronic form of this condition may improve general health and mitigate or eliminate the symptoms with positive lifestyle changes and a course of integrative treatment. Patients exhibiting early stages of this condition will be identified by the Intervention Process which may delay or prevent the serious consequences of this condition with positive lifestyle changes and a course of integrative treatment

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Distribution of Paid Claims by Guideway

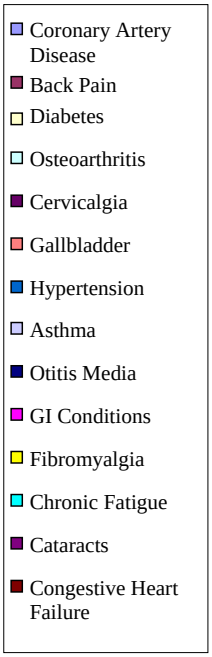

EXHIBIT V – ABC CODES CONTRIBUTED TO GROWTH OF A MEDICARE ADVANTAGE PLAN

BRIDGES IN MEDICINE®
HEALTHCARE
Incorporated

Bridges in Medicine™ Proposal for Lovelace Health Plan
Integrative Healthcare Program Under the Gold and Turquoise Plans

1) Executive Summary

   a) Medicare+Choice plans around the country are challenged with increasing medical cost ratios.

      i) For each new Medicare beneficiary Medicare+Choice plans attract, the unfavorable financial spread between the government payment and the medical cost per beneficiary is growing at an estimated rate of 13% per year.

      ii) As a result, Lovelace may be challenged with medical costs that exceed its revenues per beneficiary based on the previous assumption.

   b) Bridges in Medicine offers a fourfold solution to this dilemma. Lovelace can direct patients through Bridges in Medicine, co-market Lovelace's MedicarePlus plans, utilize Bridges'consulting services, and develop and co-market all of Lovelace's other health plans.

      i) Direct patients with high cost and complementary and alternative medicine (CAM) responsive diagnoses through the Bridges in Medicine program to avoid costly conventional interventions and thereby reduce the total cost of care.

      ii) Co-market Lovelace's MedicarePlus (Gold and Turquoise plans) integrative medicine programs to attract healthier beneficiaries, and to thereby increase revenues while reducing corresponding medical costs.[1]

      iii) Utilize Bridges'consulting and integrative medical model to develop a prototype for Lovelace plans that can be used in other high cost diagnoses and thereby reduce the total cost of care.[2]

      iv) Develop and co-market an integrative model for Lovelace's other health plans to enhance market share and promote a unique brand image. This would be a joint venture capitalizing on Lovelace's pioneering and innovative reputation, with the intent of collecting presently unavailable data on disease management. This would promote research and new models of care to better serve our patients.[3]

[1] Under the Sandia Health Plan, The MedicarePlusTurquoise program has been on going for four years. We believe an analysis of the Turquoise Plan loss ratio will support our contention.
[2] Presently the Sandia Turquoise/Gold plans are the only Medicare approved programs of their kind in the country.
[3] Dr. William Mitchell (CMO of Sandia Health Systems) and Bridges in Medicine™ are presently revisiting how to integrate his electronic diagnostic program with our integrative model. This could have an important effect on the aforementioned.

3924 Carlisle Boulevard NE • Albuquerque • New Mexico 87101 • (505) 855-5545 • Fax (505) 855-5541 • Web site: www.BridgesinMedicine.com

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HEALTHCARE
Incorporated

2) Program Overview

a) Directing of Patients

i) Bridges understands the high cost diagnoses that are likely to be the main drivers of Lovelace's medical cost ratio and employers' lost work days:

Condition	ICD-9	# of Missed Work Days (Annual)
1. Osteoarthritis	715.9	20.12
2. Diabetes	250.0	18.81
3. Hypertension	401	14.3
4. Gastroenteritis	558	6.9
5. Back Pain	847	6.4
6. Migraine	346	6.4
7. Carpal Tunnel	354.0	10
Source: Work Loss Data Institute, Disability Guidelines 2001		

ii) Bridges has cutting edge information on CAM responsive diagnoses:

Diagnosis	ICD-9
1. Hypertension	401.9
2. Arthritis	447.6
3. Chronic Headache	784.0
4. Chronic Sinusitis	473.9
5. Sleep Disorders	780.50
6. Depression	311
7. Fibromyalgia	729.1
8. Fatigue	780.79
9. Back Pain	724.2
10. Irritable Bowel	564.1
11. Coronary Artery Disease	414.00
12. Cerebral Vascular Disease	436

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iii) Bridges understands the top 10 physical conditions, ranked by total payments, for all industries payments, for all industries.

Top 10 Physical Conditions, Ranked by Total Payments (All Industries) *Total Number of Insured Lives = 4,106,124*			
Condition	**Number of Patients**	**Average Payment**	**Total Payments (in Millions)**
1. Coronary Artery Disease (w/o prior bypass graft)	100,682	$4,639	467.1
2. Disorders of the Gastrointestinal Tract, NEC	306,972	563	172.9
3. Essential Hypertension	327,723	472	154.7
4. Vaginal Delivery	37,741	4217	146.5
5. Osteoarthritis	123,444	1179	145.5
6. Back Disorders, NEC	285,453	504	144.0
7. Diseases of Ear, Mastoid Process, Nose or Throat, NEC	628141	216	135.5
8. Diabetes Mellitus	121,535	1081	131.4
9. Cerebrovascular Disease	31266	3662	114.5
10. Cholecystitis & Cholethiasis	23,297	2724	110.1
Notes: "Conditions" excludes symptoms, signs, other conditions; preventive health care; nonspecified symptoms, signs, other conditions; and administrative health encounters from the ranking calculations.			
Source: Goetzel et al., Journal of Occupational and Environmental Medicine, April 2000			

iv) Lovelace can immediately target the overlap between high cost and CAM-responsive diagnoses to generate cost savings. By directing patients with these high cost (i.e. chronic diseases) and CAM responsive diagnoses through the Bridges in Medicine program, Lovelace may reduce the medical cost ratio.

b) Utilizing the Bridges in Medicine™ Model

i) Bridges in Medicine will review Lovelace's current utilization management programs; and suggest short, medium and long-term enhancements to address the cost-saving and quality-enhancing opportunities offered by integrative medicine.

(1) Bridges in Medicine™ will help create prior authorization guidelines and treatment plans for integrative medicine responsive diagnoses.

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(2) Bridges in Medicine™ will suggest measurement solutions to allow for concurrent and retrospective evaluation of economic, clinical, health, quality of life and patient satisfaction outcomes.

(3) Bridges in Medicine™ will provide real time high cost case oversight to reduce financial exposure for cases that are not responsive to initial interventions.

c) Co-marketing to Attract Preferred Beneficiaries

i) Bridges will educate Lovelace's marketing and product management teams about generally understood patient preferences in integrative healthcare.

ii) Bridges will assist Lovelace in determining the specific integrative medicine preferences of their health plan population.

d) Co-marketing to Enhance Lovelace's Brand Image

i) Bridges in Medicine™ will allow you to maintain an already existing name brand recognition, which presently has no competition in the New Mexico healthcare market.

ii) Bridges in Medicine™ will also provide web site links that feature Gold and Turquoise plans (integrative medicine programs).

iii) Bridges in Medicine™ will write articles and provide public speaking services that reference Lovelace's Gold and Turquoise plans (integrative medicine programs).

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Figure 9. Diagnoses for which Medicare Advantage patients are seeking integrative healthcare.

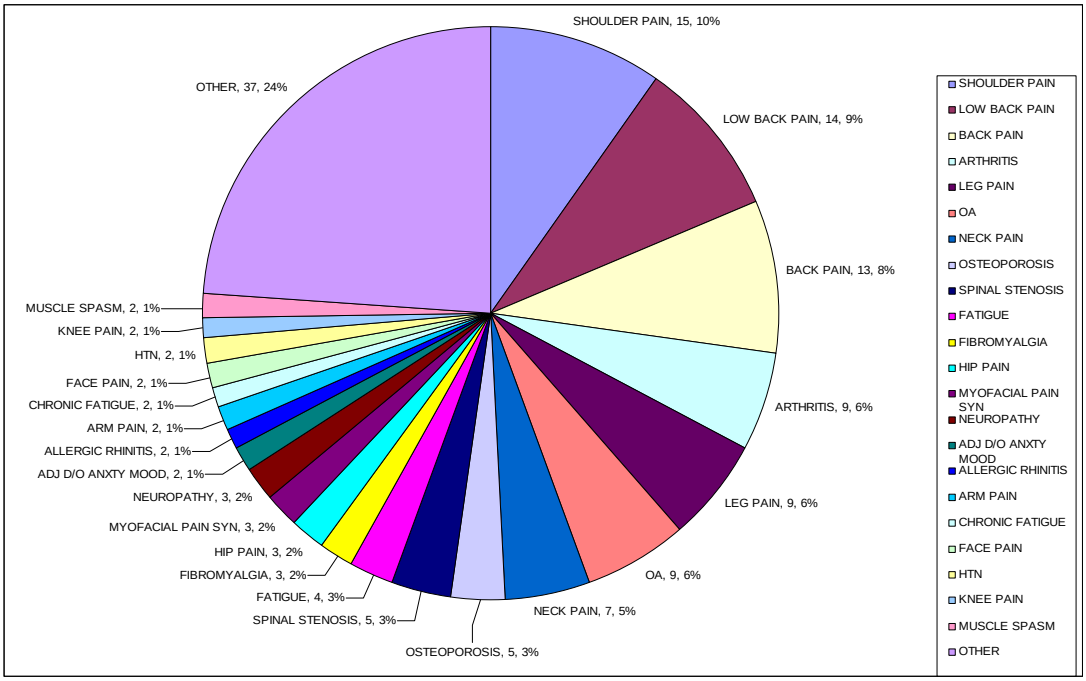

Figure 10. Distribution of acupuncture treatments across diagnoses, for Medicare Advantage patients.

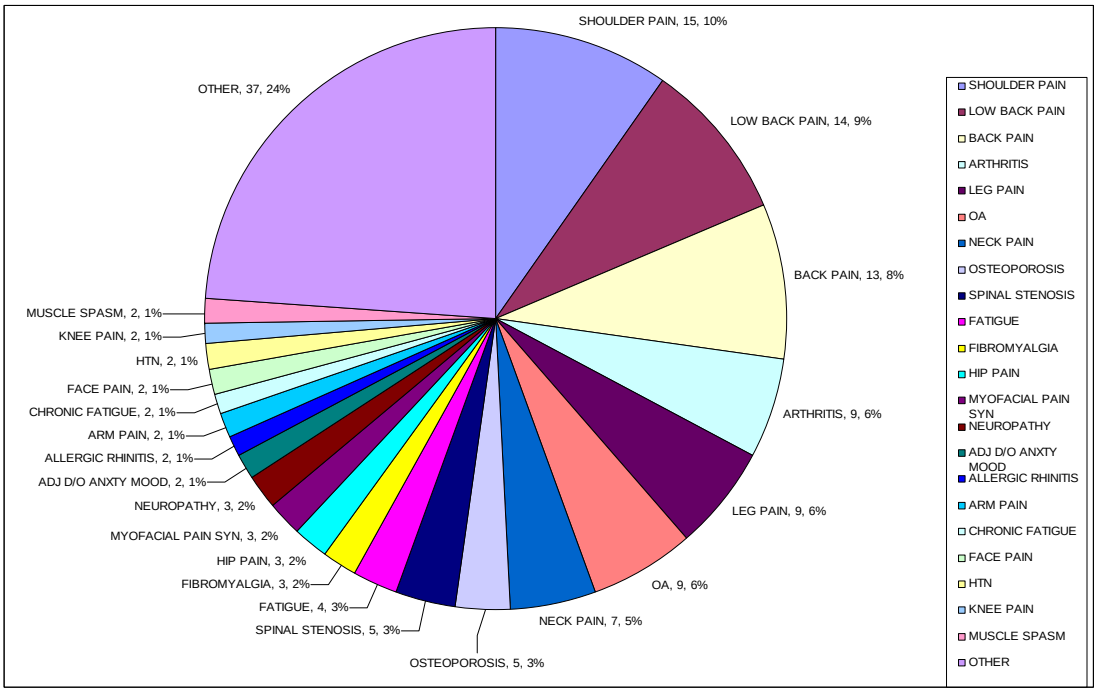

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EXHIBIT W – AETNA IS DEPLOYING ABC CODES TO SUPPORT OPM AND OTHERS

JUN 14 '04 11:02 FR AETNA 703 288 9808 TO 915058750002 P.02/03

Aetna™

James D. Cross, M.D.
National Medical Director
Medical Policy & National Transplant

CrossJD@aetna.com
tel: 301-636-1119
fax: 301-636-1909
1301 McCormick Drive
Largo, Maryland 20774

June 11, 2004

Synthia L. Molina
Chief Executive Officer
Alternative Link Systems, Inc.
6121 Indian School Road NE, Suite 131
Albuquerque, New Mexico 87110

Dear Ms. Molina:

Under our confidentiality agreement, we will continue to address with you the specific areas in which we see strategic opportunities for deploying ABC codes, relative value units, practitioner identifiers, legal practice guidelines and other coding-related solutions. We welcome the opportunity to discuss some of these plans with your highest level contacts within the public and private sectors. We are particularly interested in speaking with the Office of Personnel Management. Confidentiality agreements may be required.

As you know, from our discussions and work together over the past 18+ months, Aetna's intention is to lead the market in using ABC codes to improve healthcare accessibility, quality and cost-management. My unit is currently considering the ABC codes as a possible means to achieve:

- administrative and medical cost savings in traditional health plan offerings
- market leadership and infrastructure improvements in the design and deployment of consumer-driven health plans
- greater assurance of provider and practitioner competencies in network design and contracting
- better health policy decision making and evidence-based improvements in utilization and clinical practice management
- insight into best practices gained through economic and health outcomes research
- reductions in health disparities among rural, impoverished, minority and ethnic populations
- greater free market competition as more practitioners are able to compete for contracts and on price, on the basis of the cost-effectiveness of the care they deliver
- empowerment of insurance beneficiaries to make better personal health and healthcare decisions based on reliable evidence of the differential outcomes of conventional, complementary and alternative approaches to care.

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JUN 14 '04 11:02 FR AETNA 703 288 9808 TO 915058750002 P.03/03

My associates and I look forward to your involvement in selected strategic initiatives here at Aetna. We invite the opportunity to address these initiatives with current and potential national accounts (e.g., in the public sector), our information technology vendors and others. We also invite the opportunity to explain to top level health policy decision makers why our getting unrestricted access to the codes sooner rather than later would support their public health interests and our ability to better serve the American public.

Sincerely,

James D. Cross, M.D.

** TOTAL PAGE.03 **

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Aetna Is Deploying ABC Codes to Support Its Consumer-Driven Health Plans

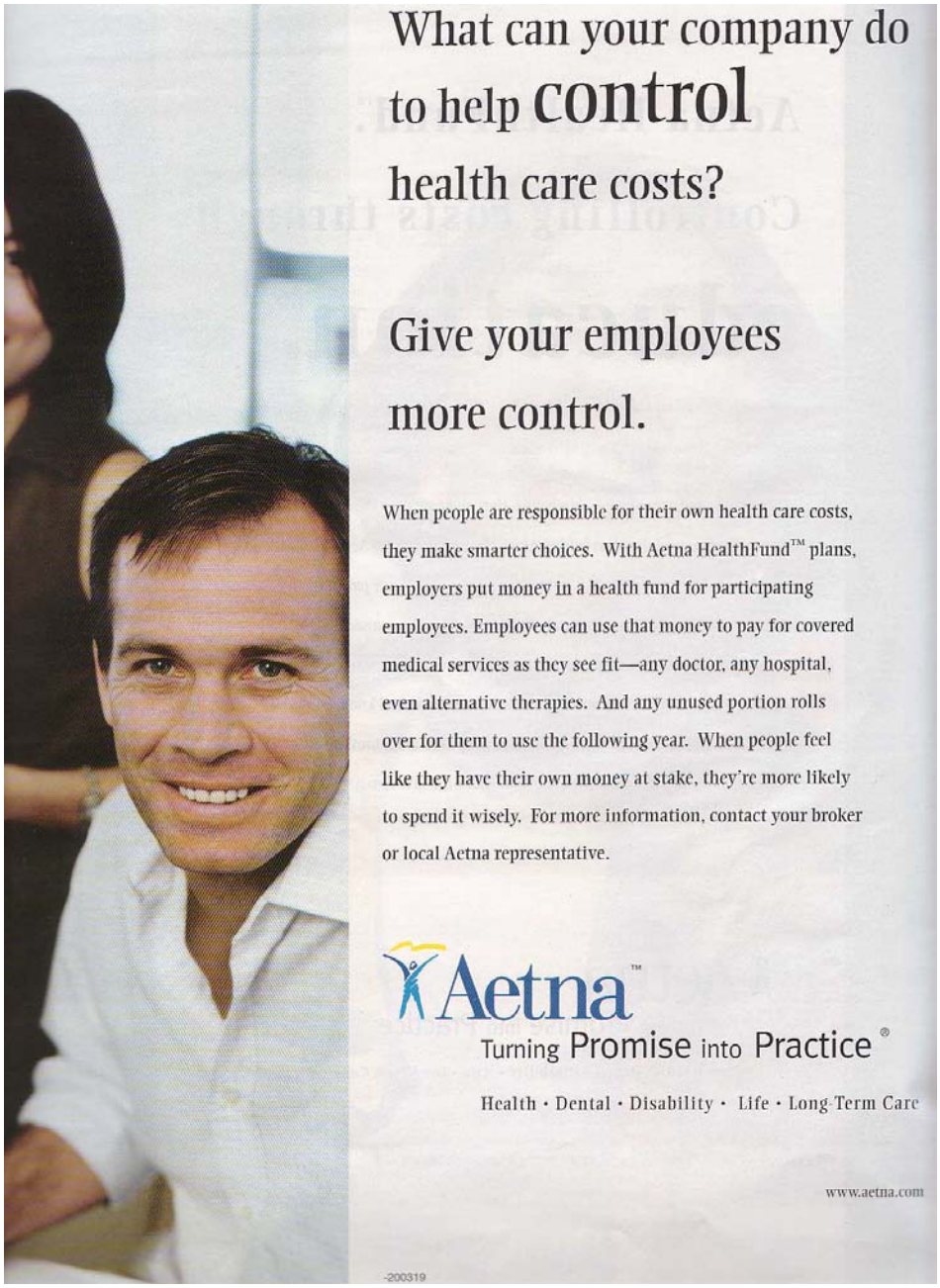
What can your company do to help control health care costs?
Give your employees more control.
When people are responsible for their own health care costs, they make smarter choices. With Aetna HealthFund™ plans, employers put money in a health fund for participating employees. Employees can use that money to pay for covered medical services as they see fit—any doctor, any hospital, even alternative therapies. And any unused portion rolls over for them to use the following year. When people feel like they have their own money at stake, they're more likely to spend it wisely. For more information, contact your broker or local Aetna representative.
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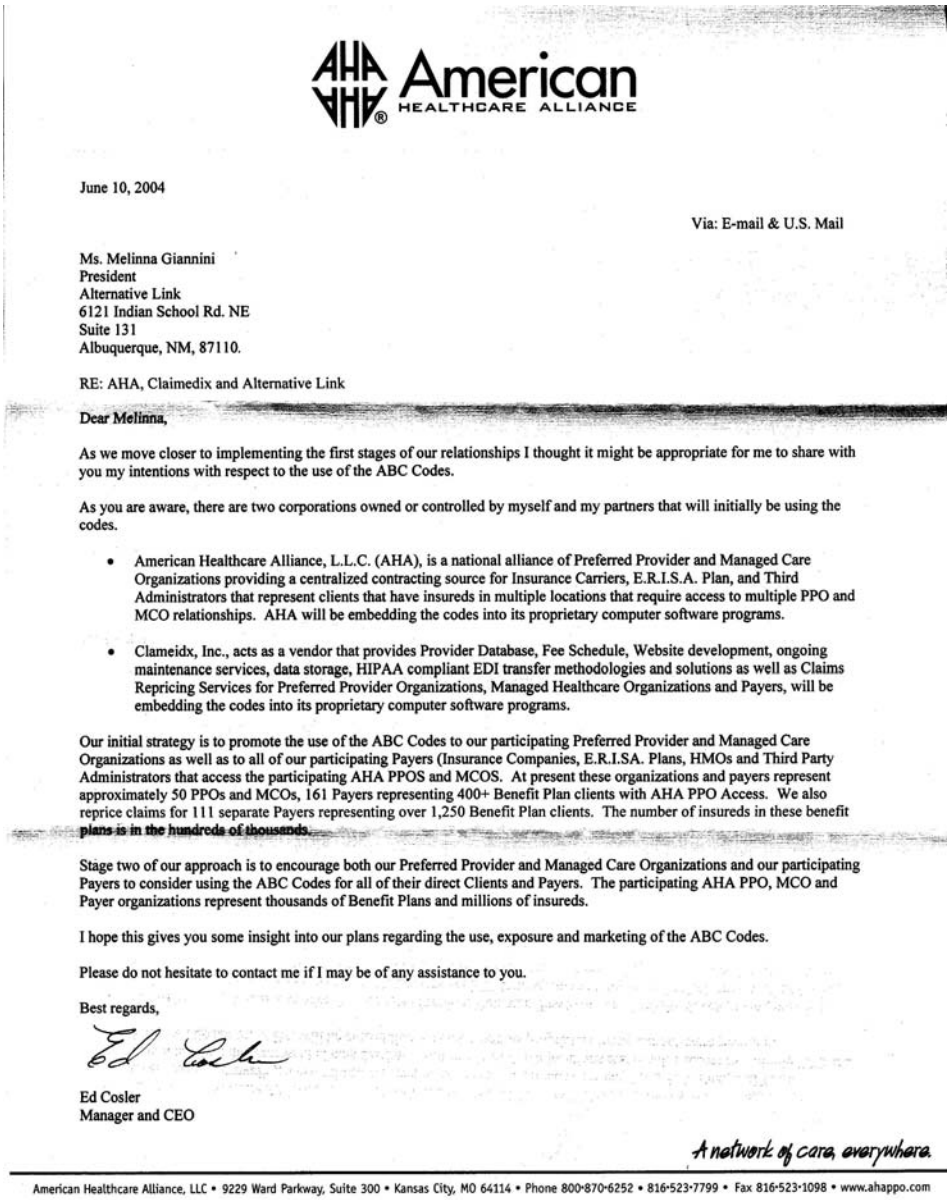
EXHIBIT X - AMERICAN HEALTHCARE ALLIANCE IS DEPLOYING ABC CODES



American HEALTHCARE ALLIANCE

June 10, 2004

Via: E-mail & U.S. Mail

Ms. Melinna Giannini
President
Alternative Link
6121 Indian School Rd. NE
Suite 131
Albuquerque, NM, 87110.

RE: AHA, Claimedix and Alternative Link

Dear Melinna,

As we move closer to implementing the first stages of our relationships I thought it might be appropriate for me to share with you my intentions with respect to the use of the ABC Codes.

As you are aware, there are two corporations owned or controlled by myself and my partners that will initially be using the codes.

- American Healthcare Alliance, L.L.C. (AHA), is a national alliance of Preferred Provider and Managed Care Organizations providing a centralized contracting source for Insurance Carriers, E.R.I.S.A. Plan, and Third Administrators that represent clients that have insureds in multiple locations that require access to multiple PPO and MCO relationships. AHA will be embedding the codes into its proprietary computer software programs.

- Clameidx, Inc., acts as a vendor that provides Provider Database, Fee Schedule, Website development, ongoing maintenance services, data storage, HIPAA compliant EDI transfer methodologies and solutions as well as Claims Repricing Services for Preferred Provider Organizations, Managed Healthcare Organizations and Payers, will be embedding the codes into its proprietary computer software programs.

Our initial strategy is to promote the use of the ABC Codes to our participating Preferred Provider and Managed Care Organizations as well as to all of our participating Payers (Insurance Companies, E.R.I.S.A. Plans, HMOs and Third Party Administrators that access the participating AHA PPOS and MCOS. At present these organizations and payers represent approximately 50 PPOs and MCOs, 161 Payers representing 400+ Benefit Plan clients with AHA PPO Access. We also reprice claims for 111 separate Payers representing over 1,250 Benefit Plan clients. The number of insureds in these benefit plans is in the hundreds of thousands.

Stage two of our approach is to encourage both our Preferred Provider and Managed Care Organizations and our participating Payers to consider using the ABC Codes for all of their direct Clients and Payers. The participating AHA PPO, MCO and Payer organizations represent thousands of Benefit Plans and millions of insureds.

I hope this gives you some insight into our plans regarding the use, exposure and marketing of the ABC Codes.

Please do not hesitate to contact me if I may be of any assistance to you.

Best regards,

Ed Cosler
Manager and CEO

A network of care, everywhere.

American Healthcare Alliance, LLC • 9229 Ward Parkway, Suite 300 • Kansas City, MO 64114 • Phone 800-870-6252 • 816-523-7799 • Fax 816-523-1098 • www.ahappo.com

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A Sample of Weekly Claims Volume at American Healthcare Alliance

14.59% of "Physician Claims" Were From Integrative Healthcare Practitioners

Weekly Claims Volume And Turnaround

9/21/2004

For Claims Processed From 8/1/2004 to 8/31/2004

Year: 2004

Inbound EDI Transactions

Week Number	Physician Claims	Facility Claims	Total	HCFA Avg. Turnaround	UB Avg. Turnaround	Weighted Avg
32	2473	461	2934	0.30 days	0.30 days	.30 days
33	2487	531	3018	0.24 days	0.44 days	.28 days
34	2662	374	3036	0.27 days	0.28 days	.28 days
35	3048	355	3403	0.34 days	0.27 days	.33 days
36	1138	72	1210	0.00 days	0.35 days	.02 days
EDI Totals:	**11808**	**1793**	**13601**	**0.26 days**	**0.34 days**	**0.27 days**

Inbound Paper Transactions

Week Number	Physician Claims	Facility Claims	Total	HCFA Avg. Turnaround	UB Avg. Turnaround	Weighted Avg
32	10996	2898	13894	2.73 days	2.50 days	2.69 days
33	15210	2297	17507	3.38 days	1.66 days	3.15 days
34	14447	1947	16394	2.82 days	1.69 days	2.69 days
35	16040	2112	18152	2.82 days	1.43 days	2.66 days
36	6682	851	7533	2.76 days	2.02 days	2.68 days
Paper Totals:	**63375**	**10105**	**73480**	**2.93 days**	**1.89 days**	**2.79 days**
Annual Summary:	**75183**	**11898**	**87081**	**2.51 days**	**1.65 days**	**2.40 days**

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EXHIBIT Y - COMMERCIAL USE OF ABC CODES IS GROWING

The **Acupuncture and Oriental Medicine National Coalition** (AOMNC) has been educating Florida Doctors of Oriental Medicine in filing claims using ABC codes. Automobile and health insurance carriers in Florida are aware of the codes because of this educational initiative and, in many instances, are paying ABC coded claims. Exposing payors to ABC codes is one of several industry-leading initiatives of AOMNC. Others include supporting the Hinchey Federal Acupuncture Bill, conducting regional lobbying in Florida and pursuing a class action lawsuit against certain health plans for discriminatory reimbursement practices.

Alternative Healthcare Options (AHO) is a fast-growing national CAM PPO network that is deploying ABC codes in support of its credentialed practitioners of acupuncture, chiropractic, naturopathy and massage therapy, and its natural herbal formulary for third party reimbursement. AHO integrates natural choices with traditional healthcare through CAM and focuses on covered benefits in the insured marketplace.

American Healthcare Alliance (AHA) had modest revenues in 2003[415] from its collaborative efforts with more than 50 Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) across the country. However, the organization influences the claims adjudication practices of health plans and provider organizations that represent more than 20 million covered lives. This year, AHA will make ABC codes available for use by all AHA-USA members under a Reciprocity Program that allows plan participants/insureds and their dependents to access healthcare providers nationwide when they are traveling, while still retaining preferred "in-network" rates and fees for services. Participating PPOs are paid at "in-network" benefit levels by the participating AHA-USA client. The AHA-USA Reciprocity Program includes thousands of hospitals and hundreds of thousands of physicians and other providers across the United States. ABC codes, practitioner identifiers, RVUs and legal practice guidelines will allow the functionality of the Reciprocity Program to be extended to IHC practices to support the needs of plan participants, practitioners, provider organizations and health plans.

Aviacode is a small Utah based business that reported modest revenues for 2003[416] and delivers "high tech" online coding services to healthcare providers using a HIPAA-compliant data center and extensive network of certified coders. The company's expert coders comply with Correct Coding Initiatives, Local Medical Review Policies (LMRPs) and other compliance mandates. Aviacode will be providing specialized coding services for IHC practitioners using ABC codes.

Bridges in Medicine, an IHC PPO in Albuquerque, New Mexico, has been using ABC codes in its IHC programs, including several Medicare Advantage offerings, for half a decade, in cooperation with **Lovelace Sandia Health System** (now part of **Ardent Health Services**). In this demonstration site, used in combination with HCPCS, ABC codes are supporting cost-effectiveness comparisons between conventional, complementary and alternative care—and MD and IHC—to improve healthcare research, management and commerce. [417]

The founder of Bridges in Medicine is now on the national lecture circuit discussing the role of ABC codes in advancing best practices, saving money, and improving bottom line performance for

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health plans, HCIT companies, provider organizations and practitioners. Referring to ABC codes as an "enabling technology," he is helping health policymakers think about how to make better decisions about what should and should not be covered and reimbursed under insurance plans.[418]

Carolinas HealthCare System is the largest healthcare system in the Carolinas, and one of the largest publicly owned systems in the nation. It owns, leases and manages hospitals, nursing homes, physician practices, home health agencies, radiation therapy facilities, physical therapy facilities, managed care companies and other healthcare-related operations. In 2003, it had $231 million in sales, approximately 17,000 employees, more than 4,419 licensed beds, and 15 hospitals.[419] [420] [421]

ABC codes are being used in patient encounter forms (*Superbills for Integrative Healthcare*) at the Carolinas Integrative Health center. The Center offers complementary therapies and systems of healthcare such as stress management, Chinese Medicine, chiropractic manipulation and massage therapy and combines complementary and traditional healthcare interventions to optimize patient health. Its medical director is Russel H. Greenfield MD, a board-certified physician with more than 20 years of experience in conventional and complementary medicine and one of the first four physicians in the world to train under Andrew Weil, MD, at the University of Arizona College of Medicine's Program in Integrative Medicine. (Dr. Weil is viewed as a 21st century pioneer in the practice of medicine.)

Conemaugh Health System is the largest and most comprehensive healthcare provider in West Central Pennsylvania. In 2002, Conemaugh had $284.4 million in sales, employed more than 3,400 individuals, maintained more than 600 hospital beds, and operated a preferred provider organization called Penn Highlands Health Plan.[422] It is deploying ABC codes as coding mechanisms for CAM services delivered to patients suffering from headache, chronic back pain and the effects of stroke. The codes, used in conjunction with value units (RVUs) will facilitate third-party reimbursement, as supported by documented clinical and fiscal outcomes.

The **Consortium of Academic Health Centers for Integrative Medicine** is supported by a grant from the **Philanthropic Collaborative for Integrative Medicine**. Its mission is to help transform medicine and healthcare through rigorous scientific studies, new models of clinical care, and innovative educational programs that integrate biomedicine, the complexity of human beings, the intrinsic nature of healing and the rich diversity of therapeutic systems. Brian Berman, MD, of the University of Maryland, is introducing the use ABC codes in the Consortium's collaborative research efforts. Twenty-two academic health centers are current members of the Consortium. They are George Washington University (www.IntegrativeMedicineDC.com), Oregon Health and Science University (www.ohsu.edu/women), University of Calgary (www.ucalgary.ca), University of Arizona, Program for Integrative Medicine (www.integrativemedicine.arizona.edu), University of California, Los Angeles, Center for Integrative Medicine (www.mbcrc.med.ucla.edu) University of California, San Francisco, Osher Center for Integrative Medicine (www.ucsf.edu/ocim), Columbia University, Richard and Hinda Rosenthal Center for Complementary & Alternative Medicine (cpmcnet.columbia.edu/dept/rehab/rehm0008.html), Duke University, Duke Center for Integrative Medicine (dukehealth.org/health_services/integrative_medicine.asp), Albert Einstein College of Medicine of Yeshiva University, Continuum Center for Health and Healing (www.healthandhealingny.org), Georgetown University, Kaplan Clinic,

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(www.georgetown.edu/schmed/cam), Harvard University, Osher Institute (www.osher.hms.harvard.edu), University of Hawaii at Manoa, Program in Integrative Medicine (www.uhm.hawaii.edu), Thomas Jefferson University, Center for Integrative Medicine, (www.jeffersonhospital.org/cim), University of Maryland, Center for Integrative Medicine, (www.compmed.umm.edu), University of Massachusetts, Center for Mindfulness, (www.umassmed.edu/cfm), University of Michigan, Complementary & Alternative Research Center (www.med.umich.edu/camrc), University of Minnesota, Center for Spirituality and Healing, (www.csh.umn.edu), University of Medicine and Dentistry of New Jersey, Institute for Complementary & Alternative Medicine (www.umdnj.edu/icam), University of Pennsylvania, Office of Complementary Therapies (www.med.upenn.edu/progdev/compmed/steering.html), University of Pittsburgh, Center for Complementary Medicine (www.upmc.com), University of Texas Medical Branch, UTMB Integrative Health Care (cam.utmb.edu/default.asp) and University of Washington, Department of Family Medicine, (www.fammed.washington.edu/predoctoral/cam).

The **Integrative Medicine Network (IMN)** invites qualified CAM practitioners to become Preferred Provider Members in the IMN Network and to gain favorable reimbursement under health insurance programs. At the same time, **IMN** encouraged its current and prospective clients (e.g., plan sponsors, employers and insurers) to provide some level of reimbursement for covered CAM benefits. **IMN** is deploying ABC codes as the foundation for fair, RVU-based reimbursement.

IHC Systems had annual sales of $110,000[423] for 2003 and is offering the first HIPAA compliant CAM practice management system, conceived by **N-CAM®** and developed by **Medical Professional Systems** and **JG Global Technologies**. The new software, known as the **ABC Remedy System**, incorporates ABC codes, and interacts with traditional payor systems while maintaining the integrity of the treatment protocols and guidelines of the CAM specialties and modalities.

JG Global Technologies is a software development firm that specializes in software solutions for the medical, financial and banking industries. The company provides patient management software and services, medical billing and collection services, and general consulting services to the medical industry. The company offers expertise in HIPAA compliance issues related to transactions, code sets and other topics and co-developed the **ABC Remedy System**, which incorporates ABC codes.

Lovelace Sandia Health System[424] has been providing healthcare coverage in New Mexico for over 80 years and offers IHC services through **Bridges in Medicine**. Its parent company, **Ardent Health Services**, had $408 million in sales in 2002 and 28 hospitals (with 21 focused on behavioral health).[425] Its senior plans include an award-winning HMO that replaces conventional Medicare coverage. Lovelace has full accreditation from the National Committee for Quality Assurance (NCQA), has been ranked as one of the Top 100 Integrated Healthcare Networks in the country by *Modern HealthCare Magazine*. It recently received the prestigious Medical Group Preeminence Award from the American Medical Group Association.

Medical Professional Systems is a division of **American Marketing**, a Chicago-area solution-based management firm with over twenty one years experience in solving problems and developing systems for Fortune 500 firms in the telecommunications, insurance and healthcare industries. Since

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1999, the MPS team has focused on the needs of the healthcare community. Merging talents and personnel with **JG Global Technologies**, the team offers practice management and revenue management solutions for IHC practices, physician practices, clinics, medical centers, surgical centers and hospitals.

MediMerge Health reported annual sales of $540,000 in 2002[426] and gives advice to the 55,000 employees (and dependents) of a Fortune 200 employer, on the proper use of CAM modalities. ABC codes are being deployed to support data capture and analysis to document the program's impact.

ABC codes will soon be used in the majority of automotive injury claims, as **Mitchell Medical** (www.mitchellmedical.com), the dominant claims review software application developer for that segment, finishes fully deploying them into its claims adjudication software, application service provider solutions and claims adjudication outsourcing services.

Mitchell International, Inc.,[427] Mitchell Medical's parent company, is the leading provider of data, software and eBusiness solutions for the automotive insurance, collision repair, medical claims and glass replacement industries. Mitchell facilitates several million electronic transactions between more than 16,000 business partners each month. Mitchell's own parts and labor database, a critical connectivity point between shops and insurers, is trusted for its accuracy and respected as the industry standard.

Mitchell serves several of the top 5 automobile insurance companies in the U.S., and many of the top 20. The company licenses a national defendable UCR database of prevailing charges that is specific to geographic areas referenced by zip codes. The database consists of more than 500 million patient encounter records that are updated regularly using pricing data from an 18-month "moving window" prior to the release date. Proprietary database logic and mapping technology as well as the expertise of a staff of clinical professionals are incorporated into the database. Mitchell's rules are supportable based on guidelines from sources such as the American Medical Association (AMA), McGraw Hill and multiple state mandated fee schedules.[428] (According to Mitchell, more than 60% of individuals injured in automotive accidents seek care from complementary and alternative medicine practitioners.)

N-CAM Wellness Benefits Company is using ABC codes and other coding-related solutions to develop uniform national credentialing standards for IHC practitioners in support of private label and co-branded wellness programs, as well as for documenting patient encounters to support practice-based research on economic and health outcomes.

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National Association of Clinical Nurse Specialists (www.nacns.org) was founded in 1995 to enhance and promote the contributions of clinical nurse specialists to the health and well-being of individuals, families, groups, and communities, and to promote and advance the practice of nursing. Clinical Nurse Specialists are licensed Registered Nurses who have graduate preparation (Master's or Doctorate) in one of 48 specialties around populations (e.g., pediatrics, geriatrics, women's health), settings (e.g., critical care, emergency room), diseases or medical subspecialties (e.g., diabetes, oncology), types of care (e.g., psychiatric, rehabilitation), and/or types of problems (e.g., pain, wounds, stress).

Clinical Nurse Specialists practice in a wide variety of healthcare settings. In addition to providing direct patient care, CNSs influence care outcomes by providing expert consultation for nursing staffs and by implementing improvements in healthcare delivery systems. Their practice integrates nursing practice (which focuses on assisting patients in the prevention or resolution of illness) with medical diagnosis and treatment of disease, injury and disability.

An estimated 69,017 Registered Nurses have the education and credentials to practice as clinical nurse specialists and approximately 14,643 are qualified to work as both nurse practitioners and clinical nurse specialists. The NACNS is collaborating with Alternative Link to further characterize the practices of all 48 specialties.

NaviMedix is an expert in eCommerce and is driving provider utilization of web-based tools that enable automation of complex information exchange between health plans and providers, focusing on both financial and medical workflows.[429]

A regional unit of **NDCLytec** supported loading of ABC codes into Bridges in Medicine's practice management system to support a New Mexico Medicare Advantage program. NDC's Electronic Commerce Services unit offers technologies to improve reimbursement, expedite collections and improve patient care. Solutions include electronic claims processing, remittance processing, statement processing, prescription processing and direct processing services.

One of the nation's pioneers in the use of ABC codes outside of electronic commerce, **Preferred Health Systems** (www.phsystems.com), uses the codes, relative values and legal billing guidelines in designing IHC benefit plans and practitioner credentialing criteria. PHS serves several of the nation's largest unionized aerospace manufacturers (whose confidentiality is protected under non-disclosure agreements with PHS) and other Kansas-based organizations.

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EXHIBIT Z –ANSI ASC X12 SUPPORTS ABC CODES

Information Concerning Presence of Qualifier Code for Complementary, Alternative, or Holistic Procedure Codes Within the X12 Standard and Version 4050 Implementation Guides

I hold the position of Co-Chair, X12N Task Group 8, Architecture Review (X12NTG8). Part of the mandate for X12NTG8 is to review all changes and additions to the X12 standard submitted by X12N to insure they are technically correct. Another part of the X12NTG8 mandate is to review all X12N Implementation Guides to insure they comply with the X12 standard on which they are based. Therefore, I have the expertise to validate that the proper qualifiers are present in appropriate X12N implementation guides to allow identification of Complementary, Alternative, or Holistic Procedure Codes.

I have verified that Complementary, Alternative, or Holistic Procedure Codes can be used in appropriate X12N Implementation Guides in version 4050. I have reviewed drafts of the version 4050 guide for the 835 Remittance Advice (004050X124), the version 4050 guide for the 837 Professional Claim (004050X143), the version 4050 guide for the 837 Health Care Services Review (004050X156), and the ASC X12 Standard, version 4050. I reviewed drafts of the named X12N implementation guides, because the final copy has not yet been published. Since the drafts I reviewed were the pre-publication drafts submitted to X12NTG8 for review, I am confident that they represent the final document that will be published.

Procedure codes identifying Complementary, Alternative, or Holistic Procedure Codes can be used when the appropriate qualifier is present in the implementation guide. The appropriate qualifier is present in these guides. Therefore, I can state with certainty that Complementary, Alternative, or Holistic Procedure Codes can be used in the appropriate version 4050 guide.

To support this statement, there are five attachments to this document:
• Extract from the X12 standard showing the existence of qualifier CAH for data element 1270 (highlighting added)
• Extract from the X12 standard showing the existence of qualifier WK for data element 235 (highlighting added)
• Extract from Draft Implementation Guide X143, the Professional Health Care Claim guide, showing the presence of code WK
• Extract from Draft Implementation Guide X124, the Health Care Claim Payment guide, showing the presence of code WK
• Extract from Draft Implementation Guide X156, the Health Care Services Review guide, showing the presence of code CAH

These document that the Complementary, Alternative, or Holistic Procedure Codes can be used in X12N 4050 Implementation Guides.

Prepared by St. George Consulting, John St.George, April 29, 2004
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EXHIBIT AA – POLITICS AND ECONOMICS DETERMINE WHO SUPPORTS ABC CODES

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Included With Permission.

Motive and Influence in Mainstreaming Integrative Medicine

Introducing the IMSI© Rating

Authors: Richard Furber and: James F. Sargent

Integrative Medicine and the Challenge of Mainstreaming

Integrative Medicine is the emerging medical specialty that incorporates the art and science of caring for the whole person – body, mind, and spirit – to treat and prevent disease, and to empower patients to create a condition of optimal health that transcends the mere absence of illness. Both outside and inside the medical profession, this concept of ***medicine of the whole person*** is gathering support. This body-mind-spirit approach integrates many disciplines and modalities, including conventional or Western treatment, physiology, biochemistry, nutrition, exercise, environment, emotions, attitudes, beliefs, social relationships, manual medicine, herbs, homeopathy, energy medicine, prayer, acupuncture, meditation, spirituality, and biofeedback, to name a few.

Integrative Medicine is based on the core belief that the practice of healing embraces a spirit of interdisciplinary and physician-patient cooperation. It incorporates conventional and alternative therapies by creating a format in which each therapy can work most effectively. Integrative Medicine gets to the core issues of healing: engaging people in their health solutions by being able to have a full spectrum of treatment options at their disposal.

As these concepts are incorporated into American medical practice, medical education, health planning, and research, reasonable standards are being established regarding the application of the body of knowledge that defines the field of Integrative Medicine. Led by the work of the National Institutes of Health, the Osher Institute at Harvard Medical School, and others, researchers are conducting studies to document the clinical and cost-effectiveness of CAM modalities. Decades of work remain to be done to supplement both the long history of CAM modalities and recent anecdotal evidence with controlled studies of efficacy. Some modalities may never yield to the double-blind, placebo controlled study. Cost effectiveness data is also in short supply, with evidence coming primarily from small scale work in CAM clinics and product companies.

Integrative medicine incorporates the ever-expanding research and applies rigorous clinical judgment, based on all of the evidence, to evaluate the full spectrum of treatment options. It is our opinion that conventional medicine and CAM, when used in tandem, support the efforts of the healthy population to remain healthy, offering plan sponsors their best opportunity to control escalating costs, manage risk, and improve health outcomes.

Therein lies the challenge: who will be willing to take financial risk on the outcome of introducing integrative medicine into health plans? Who will champion it? Who will oppose it? Why? Who has enough market influence to make it happen? These are critical questions for any organization looking to build on integrative medicine research to create programs, products, or services for health plan sponsors. The answers impact choice of development partners, product design, and marketing strategy. For health plan sponsors, the employers who bear the burden of healthcare costs that are rising at an annual rate of 15%, the answers help clarify whom they can look to for advice and support. At the public policy level, the answers affect choices of legislative action, funding support, and political action agendas.

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We have tried to clarify the landscape by rating the stakeholders in the healthcare system on two dimensions: their motivation to champion the evolution of integrative medicine, and their ability to impact the direction of the healthcare market. We assigned values to multiple facets of the "Motivation" and "Influence" parameters, combined the scores, and generated an **"Integrative Medicine Support Index"** or **"IMSI Rating."** We encourage everyone whose mission is to foster the use of the most medically appropriate and cost-effective medicine to use the ratings to enhance their chances of success.

Rating the Stakeholders

To understand who is likely to shape the market for integrative medicine and why, we analyzed the major health industry stakeholders on the dimensions of Motivation and Influence. Our Motivation score is made up of five factors: revenue source; perceived benefit from health care cost increases; perceived benefit from better health plan loss ratios; the relative difficulty of overcoming the stakeholder's primary objection; and the relative difficulty of satisfying the stakeholder's primary drive to act. Our Influence score is similarly composed of three factors: the centrality of their relationship to the health care system; their perceived influence on plan sponsors; and their perceived influence on other stakeholders/customers.

Motivation Factors	
Security of revenue sources	How much will integration threaten the client base?
Benefits from cost increases	Is there a direct benefit, such as increased revenue, from rising health care process?
Benefits from better loss ratios	Is there a benefit if health care claims are reduced in comparison to premium? Does the benefit accrue directly to the stakeholder?
Difficulty of overcoming objections	Is the challenge one of providing convincing data, or is the issue one of revenue loss, or loss of autonomy, or simply inertia?
Difficulty of satisfying the drive to act	Is this a simple challenge of proven cost savings, or is it an issue of compensation, professional recognition, or politics?

We assigned different weights to each Motivation factor, a process that reflects our own collective experience with the health care industry. Highest impact was assigned to the first two factors – benefiting from cost increases and benefiting from improved loss ratios – because we believe that following compensation incentives is the surest way to assess a stakeholder's commitment to success.

Influence Factors	
Relationship to the health care system	How central are they to the processes of defining available insurance coverage, evaluating risk, and pricing?
Perceived influence on plan sponsors	How much control do they exert over a health plan sponsor's coverage selections?
Perceived influence on other customers	Each stakeholder may have influence over other stakeholders, regulators, or even patient choices

The weights assigned to Influence factors covered a narrower range than the Motivation values, with the most impact assigned to "Perceived influence on plan sponsors."

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Relative Rankings on Motive and Influence Scales			
	Motive		**Market Influence**
Reinsurers	**1**	**Insurers, HMO's, Blue Cross Plans**	**1**
Plan Sponsors	**2**	**Reinsurers**	**2**
Insurers, HMO's, Blue Cross Plans	**3**	**Managing General Underwriters**	**3**
Alternative Medicine Networks	**4**	**Plan Sponsors**	**4**
Managing General Underwriters	**5**	**Pharmaceutical Companies**	**5**
NIH and other research organizations	**6**	**Alternative Medicine Networks**	**6**
Consultants	**7**	**Consultants**	**7**
Utilization Management Companies	**8**	**Third Party Administrators**	**8**
State & Federal Government	**9**	**State & Federal Government**	**9**
Third Party Administrators	**10**	**Insurance Brokers**	**10**
Insurance Brokers	**11**	**Physician practice groups and networks**	**11**
Physician practice groups and networks	**12**	**NIH, and other research organizations**	**12**
Pharmaceutical Companies	**13**	**Utilization Management Companies**	**13**

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The IMSI© Ratings

Readers will understand that any attempt to put numerical values on what many will consider to be common sense evaluations is, in itself, a subjective process. The authors undertook the IMSI© Rating project as a way to force objective thinking about the forces that underlie change – provider driven, insurance industry driven, or consumer driven – in the world of health care. If we are correct in our assessment of each stakeholder's relative position on each factor, our overall scoring should reflect the real marketplace.

The impact of the combined factor scoring is to give the highest rating to the stakeholder who is in a position to influence the decision of health plan sponsor, is in a position to profit directly from an improvement in loss ratio, and who is unlikely to suffer any adverse economic consequences from health care premiums that are tending toward stabilization. Lowest scores go to stakeholders who will be financially disadvantaged by the mainstreaming of integrative medicine, who are removed from health plan sponsors who make decisions on plan features, and who have limited interest in improving loss ratios. The major factors are tempered in some cases, augmented in others, by the weights assigned to the threat to a stakeholder's client base, barriers to overcoming objections, and the other factors

IMSI© Ratings

Sizing up Support for Integrative Medicine

Aggregate Scores for Motive and Market Influence

Key Stakeholders in the drive to mainstream IM	MediMerge Integrative Medicine Support Index
Reinsurers	**147.0**
Insurers, HMO's, Blue Cross Plans	**137.7**
Plan Sponsors	**107.1**
Managing General Underwriters	**89.8**
Alternative Medicine Networks	**68.8**
Consultants	**26.9**
NIH, and other research organizations	**25.1**
Utilization Management Companies	**9.3**
State & Federal Government	**8.0**
Third Party Administrators	**-12.0**
Insurance Brokers	**-18.0**

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Physician practice groups and networks	**-29.9**
Pharmaceutical Companies	**-83.8**

Planning Implications

In our introduction we raised several questions for organizations building on integrative medicine research to create programs, products, or services for health plan sponsors. Here are the answers suggested by the IMSI© Ratings

Who will be willing to take financial risk on the outcome of introducing integrative medicine into health plans?
The ratings suggest that reinsurers should be the primary focus of plan developers, followed closely by health insurance companies and plan sponsors. This power locus of the entity with legal responsibility for the health plan (the plan sponsor), the insurance company (when the health plan is insured), and the reinsurers (when the health plan is self-insured), have all of the correct incentives to act in a rational fashion to promote integrative medicine. Managing general underwriters, who select business on behalf of insurance companies, are downstream in the decision making process, but can still be part of the marketing equation. CAM networks rate high on Motive, but lack sufficient Influence to make their product a mandatory part of plan design. The ratings suggest that approaching any of the other stakeholders as development partners would be a waste of time and resources. The low rating for insurance brokers is interesting: many integrative medicine plan developers look to brokers as a natural distribution channel, but the ratings suggest that this approach is unlikely to produce meaningful results.

Who will champion the mainstreaming of integrative medicine?

To be a "champion," a stakeholder needs both sufficient drive to act and sufficient standing to be heard. We propose that the most likely champions are those in the top 5 in our ratings. The top 5 would not include consultants, who we judged as having weak incentives on the cost reduction and loss ratio improvement dimensions. Nor would the NIH or other research organizations make the "champion" list: while they certainly influence public perception of the value of particular therapies, they are not incented to improve health plan financial results.

Who will oppose IM mainstreaming?

Readers will not be surprised to see pharmaceutical companies and physician groups as the leading opposition. Insurance brokers, because they typically lose income to the extent that plan costs drop, stabilize, or slow their growth rate, have the wrong financial incentives to support mainstreaming. Third party administrators, who might have an incentive to incorporate integrative medicine options, are handicapped by both their compensation structure and their technical capability to administer new benefits.

Who has enough market influence to make it happen?

As the overall IMSI© Ratings and the relative positions on the Influence scale suggest, there are only four stakeholders with enough market influence to create change. The top 4 in the ratings have direct influence over some combination of plan design, risk selection, and pricing.

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How should funding be targeted?

This is a public policy issue that will become increasingly important as we approach the next election cycle. NIH has significant research funds at its disposal. Research organizations such as the Osher Institute, teaching institutions such as Bastyr University, and private companies such as Alternative Link are conducting both research and demonstration projects related to both alternative medicine and integrative medicine. The IMSI© Ratings imply that for research to support the mainstreaming of integrative medicine, it must include a cost-effectiveness component; arguments based solely on medical efficacy will not be enough to sway the stakeholders at the top of the ratings.

Where should plan sponsors be looking for advice and support?

First, we want to flip this question over and ask, "Who should plan sponsors *not* be looking to for advice?" The ratings suggest that the four groups at the bottom of the ratings cannot be expected to give reliable input; their incentives are not, and perhaps never will be aligned with integrative medicine innovation. Consultants, to the extent that their compensation is fee-based rather than commission-based, will continue to be the choice for most large employers. What the ratings show is that plan sponsors should not assume that their consultants want to take an active role in making change happen. Instead, plan sponsors should take the initiative to require their consultants to gather, analyze, and report on the initiatives of the top five in the ratings. Note that the required input should always include the initiative of other large plan sponsors – what are the innovative early adopters doing, and why?

Who are the best development partners for entities with ideas on how to promote integrative medicine?

The best ideas will succeed beyond the stage of trivial experimentation only when the major supporting stakeholders can be engaged in development and marketing. Ideas must be researched, tested, and documented in a way that that demonstrates financial impact. Estimated return on investment and the associated contractual guarantees must be sufficiently compelling that decision makers ranking above consultants in the ratings, can make an informed business decision to support development through a beta-test, pilot project, regional introduction, or other limited-risk introduction.

What elements of plan design are most likely to draw support from market influencers?

All of the top stakeholders in the ratings are concerned with efficacy, risk in several forms, and financial return. Plan design has to focus on elements that have shown both a reasonable chance of producing results better than relying on conventional medicine alone, while always meeting the "first, do no harm" standard that conventional medicine holds to. Innovations should show a high likelihood of reducing the overall trend of medical care cost increases. Beyond this likelihood, the likely impact of plan design changes should be quantifiable in advance and measurable at reasonable points in time, including the end of the health plan year.

What elements will be critical to marketing integrative medicine solutions?

If the first marketing must be to the market influencers – the top five stakeholders in the ratings – then the same plan design elements of efficacy, risk reduction, and measurable financial return will be the controlling factors. Skilled clinical review of pilot project outcome will be needed to verify health improvement. Underlying the financial analysis, especially as marketing moves beyond early adopters, is the ability to demonstrate that integrative medicine expenditures are *replacement costs,* not *additive costs.* That approach will demand rigorous data gathering and analysis from pilot projects – and being able to measure the delta between treatment options.

What are the implications for public policy in the near term?

Health care cost and access will be one of the top three domestic issues in the next presidential election cycle. The ratings suggest that discussion of integrative medicine and the role of the NIH in supporting research should steer in the direction of the financial implications of IM, and the resulting improvement of access to health insurance, and the goal of affordability. The ratings suggest that there is little to be gained from using integrative medicine research to foster debate with pharmaceutical companies or representatives of the conventional medical community.

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Concluding thoughts

There are many stakeholders in the process of research, innovation, organized debate, consumer choice, lobbying, health plan design, and risk analysis that swirls around integrative medicine. We approach integrative medicine from the perspective of those who believe that the mainstreaming of IM represents a significant opportunity to improve both the cost and quality of medicine as it is practiced in the United States. We see little else on the horizon that has shown any promise to reduce the current trend in health care cost, a trend that has the potential for serious negative impact on the cost and availability of health care.

Those on the affirmative side of this discussion can benefit from understanding which stakeholders support – and which oppose – the concept of mainstreaming IM.

By rating the stakeholders in the healthcare system on two dimensions, their motivation to champion the evolution of integrative medicine, and their ability to impact the direction of the healthcare market, and combining the dimensional ratings into a single IMSI© Rating, we offer plan developers and service entities a tool for prioritizing their actions. By focusing on motive to support mainstreaming and ability to influence market choices, we have created a stakeholders' ranking that highlights the major financial players as the ones who will make or break the effort to mainstream integrative medicine. This analysis suggests that the argument in favor of mainstreaming will be centered on efficacy, risk reduction, and measurement, concerns of the top tier of stakeholders, while opposition will center on issues of lost revenue and shrinking market share, concerns primarily of the lowest tier of stakeholders.

It is interesting to note that the lowest tier in our ratings carries a lot of influence in the health care system. The corollary, that shifting the health care balance toward integrative medicine will inevitably involve a shift in the balance of power within the system, tells us that there will be no easy battles. It is the nature of paradigm shift, though, that change often seems to have happened overnight, once enough small skirmishes have been won.

Richard Furber, Founder, Chairman & CEO, MediMerge Group LLC
Mr. Furber founded MediMerge Group LLC and its subsidiary companies; MediMerge Integrative Medical Review, Advanced Health Technologies and Wellness101 with the vision to create a complete healthcare delivery system where members did not have to be ill to receive benefits; to foster a better alignment of interest between payers and members through early intervention, preventative care and integrative medicine. He is the former CEO of Biological Technologies International, Inc, a cutting edge bio-medical device company. Prior to his focus and commitment to the healthcare industry during the last 7 years, Mr. Furber spent 17 years working in prominent positions for Wall Street firms including Managing Director Lehman Bros International and 6 years as President of Dean Witter Capital Markets International, Inc. rfurber@medimerge.com

James F. Sargent, CLU, EVP of Risk Management, MediMerge Health Inc.
Mr. Sargent is an experienced entrepreneur who has created and managed companies in the fields of health benefits consulting (The Boylston Group), managed occupational health (Healthcare First), and complementary and alternative medicine (The Tapestry Group). He co-authored the "Medical Care Access Study" for the Massachusetts Workers' Compensation Advisory Council; the study became one of the key building blocks for Workers' Compensation insurance reform in Massachusetts. With MediMerge Health, Inc. Jim manages all service operations and relations with insurance carrier partners. jsargent@medimerge.com

MediMerge Health, Inc., Manchester, MA
Offers self-funded health plans a single source for a powerful array of integrative management services to improve health outcomes, bring employee populations to a state of optimal health, reduce medical claims, and limit risk.
www.medimerge.com info@medimerge.com

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ENDNOTES

[1] Synthia Laura Molina, CEO, Alternative Link, from an analysis of the DM Eisenberg, RB Davis, SL Ettner, S Appel, S Wilkey, M Van Rompay, RC Kessler, Center for Alternative Medicine Research and Education, Department of Medicine, Beth Israel Deaconess Medical Center, Boston, "Trends in Alternative Medicine Use in the United States: 1990-1997:Results of a Follow-Up National Survey," JAMA, November 11, 1998; 280 (18): 1569-75; "National Ambulatory Medical Care Survey," National Center for Health Statistics, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, 1998, 1999, 2000, 2001; Barnes P, Powell-Griner E, McFann K, Nahin R. *CDC Advance Data Report #343*. Complementary and Alternative Medicine Use Among Adults: United States, 2002. May 27, 2004, on September 2004; .

[2] Under HIPAA, a "code set" is any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnosis codes, or medical procedure codes. Medical data code sets used in the health care industry include coding systems for diseases, impairments, other health related problems, and their manifestations; causes of injury, disease, impairment, or other health-related problems; actions taken to prevent, diagnose, treat, or manage diseases, injuries, and impairments; and any substances, equipment, supplies, or other items used to perform these actions. Code sets for medical data are required for data elements in the administrative and financial health care transaction standards adopted under HIPAA for diagnoses, procedures, and drugs.

[3] Alternative Link is working in collaboration with the Foundation for IHC, a 501[c][3] non-profit ally that was launched by the Company and then spun off as a separate legal entity with a separate Board of Directors to assist the IHC community with its role in ABC terminology development and to provide continuing education around use of health metrics in outcomes research. FIHC is not yet fully operational under the new leadership, so, in the interim, Alternative Link is working directly with IHCP associations to support terminology development. Among these are NACNS, ANA, AAOM, COCSA and others.

[4] Precedents for a designation of this type are described in a legal analysis that has been submitted, under separate cover, to the Office of the Secretary at the U.S. Department of Health and Human Services.

[5] Michael, Best and Friedrich, LLC (http://www.mbf-law.com/ as of September 29, 2004) Brian Annulis is a partner and a member of the Health Care Practice Group. Mr. Annulis' practice concentrates in health care law with a special emphasis on matters involving fraud and abuse, corporate compliance, HIPAA and reimbursement under the Medicare and Medicaid programs. Following law school, Mr. Annulis was an attorney with the United States Department of Health and Human Services, Office of the General Counsel, Health Care Financing Division. He concentrated in Medicare reimbursement and litigation matters. Saint Louis University School of Law (J.D., cum laude, 1992) Saint Louis University School of Public Health (M.H.A., with honors, 1992) Loyola College (B.A., magna cum laude, 1988) Chris Mohrman is an associate focusing his practice on complex commercial litigation and administrative and regulatory law. Prior to joining the firm, he was a member of the Administration of Wisconsin Governor Tommy G. Thompson for eight years. Mr. Mohrman served as a policy/budget advisor and liaison to the State Senate. After that, Mr. Mohrman served as Executive Assistant to Department of Administration Secretary James R. Klauser, and then as Executive Assistant to Department of Commerce Secretary William J. McCoshen. In addition to participating in major litigation matters, Mr. Mohrman counsels clients on a variety of administrative and regulatory matters before local, state and federal governments. University of Wisconsin Law School (J.D., with honors, 1999) University of Wisconsin - Madison (B.A., with distinction, 1990)

[6] In relation to HIPAA-related electronic commerce, ABC codes

1. improve the efficiency and effectiveness of the healthcare system by leading to cost reductions for, or improvements in benefits from, electronic healthcare transactions;
2. meet the needs of the health data standards user community, particularly healthcare providers, health plans, and healthcare clearinghouses;
3. are uniform and consistent with the other standards adopted under HIPAA and, as appropriate, with other private and public sector health data standards;
4. have low additional development and implementation costs relative to the benefits of using them as a standard;
5. are supported by an ANSI-accredited standard-setting organization (SSO) or other private or public organization that will maintain the standard over time;
6. have timely development, testing, implementation, and updating procedures to achieve administrative simplification benefits faster;

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7. are technologically independent of the computer platforms and transmission protocols used in electronic health transactions, except where these are explicitly part of the standard;
8. are precise, unambiguous, and as simple as possible;
9. result in minimum data collection and paperwork burdens on users; and
10. incorporate flexibility to adapt more easily to changes in the healthcare infrastructure (such as new services, organizations, and provider types) and information technology.

[7] CMS, "Impact Analysis," Retrieved from the internet on September 17, 2004 from http://www.cms.hhs.gov/hipaa/hipaa2/regulations/identifiers/providerNPRM/npi10.asp

[8] HIPAARegs, "Administrative Simplification Compliance Act" Retrieved from the internet on September 19, 2004 from http://www.hipaadvisory.com/regs/asca/asca.htm

[9] This figure was derived from 629 million reported visits to CAM practitioners in 1997 (Eisenberg/Harvard Study, 1998), and a compounded annual growth rate of 14.2%.

[10] CPT is an acronym for the American Medical Association's Current Procedural Terminology, a code set named a national standard under HIPAA in the August 17, 2000 Final Rule published in the Federal Register.

[11] CDT is an acronym for the American Dental Association's Current Dental Terminology, a code set based on the Code on Dental Nomenclature and named a national standard under HIPAA in the August 17, 2000 Final Rule published in the Federal Register.

[12] MD is the acronym for medical doctor.

[13] Occupational Outlook Handbook, 2004-05 Edition, "Dentists." Retrieved from the internet on September 17, 2004 from www.ama-assn.org and www.bls.gov/oco/print/ocos072.htm

[14] The term "physicians" refers to medical doctors (MDs) and doctors of osteopathy (DOs). The term "dentists" refers to doctors of dental surgery (DDSs), and dental medicine doctorates (DMDs).

[15] White House Commission on Complementary and Alternative Medicine Policy, Final Report, March 2002.

[16] Retrieved from the Internet on October 6, 2004 from http://www.holisticmedicine.org/index.shtml

[17] NEJM, August 21, 2003.

[18] 2004 Healthcare Business Market Research Handbook

[19] Public Citizen Report, Mid-2003.

[20] Tommy G. Thompson and David J. Brailer, "The Decade of Health Information Technology: Delivering Consumer-centric and Information-rich Health Care," U.S. Department of Health and Human Services, Office of the National Coordinator for Health Information Technology, July 21, 2004.

[21] Title 45, Public Welfare and Human Services, Part 162, Administrative Requirements, Subpart I, General Provisions for Transactions, Section 162.940, Exceptions from standards to permit testing of proposed modifications.

[22] For example, ABC codes and the previously named HIPAA transaction and code set standards will jointly contribute more to a consumer-centric and inter-operable NHII than the prior HIPAA standards could contribute in the absence of ABC codes.

[23] Alternative Link submitted a binder to HHS in response to the proposed rule published in the Federal Register, Volume 63, Number 88, in May 1998, in reference to file code HCFA-0149-P. The binder contained a cover letter and documentation that established ABC codes' compliance with each of the ten guiding principles for HIPAA standards. This document is available upon request.

[24] Federal Register/Vol. 65, No. 160/Thursday, August 17, 2000/Rules and Regulations.

[25] Without a standards designation, ABC codes and other proposed code sets (e.g., ICD-10-CM and PCS) face a *catch 22* and *first mover disadvantage* in relation to industry adoption. Regardless of their cost-benefit, the code sets are viewed as a risky investment because they have not been mandated under HIPAA, yet HHS viewed widespread industry adoption as a key driver of the HIPAA standard-setting process. Alternative Link believes the data collection challenges generated by this catch 22 and the first mover disadvantage can be overcome by 1) recognizing that industry adoption of ABC codes has been limited by their status relative to HIPAA and the registration mandates associated with their use; and 2) focusing on what has already happened in early deployment initiatives (e.g., with a Medicare Advantage program and with one of the nation's largest commercial health plans) that has yet to have full impact.

[26] "Frequently Asked Questions About Code Set Standards Adopted Under HIPAA." Retrieved from the Internet on September 15, 2004 from http://aspe.hhs.gov/admnsimp/faqcode.htm

[27] CMS was formerly known as the Health Care Financing Administration.

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[28] One challenge with the HIPAA code sets was that they focused on care delivered by conventional doctors and dentists and were overseen by bodies that, to a great degree, directly represented the interests of these professions. Under these circumstances, in the absence of ABC codes, practitioners other than conventional doctors and dentists were forced to submit coding applications to competitors that may have had political and financial reasons (e.g., competition for healthcare dollars) to withhold complete, accurate and precise codes.
[29] 45 CFR 162.940
[30]Martin Libicki and Irene Brahmakulam, "The Costs and Benefits of Moving to the ICD-10 Code Sets," Technical Report Prepared for the Department of Health and Human Services (Rand Science and Technology, March 2004) p.1.
[31]Sandra McCarver and Liza Moran on behalf of WEDI, "Data and Code Set Compliance: A White Paper Describing the Business Issues and Recommended Short and Long Term Solutions Associated With Data and Code Set Compliance," Draft, January 11, 2001, p. 5. Retrieved from the internet on September 19, 2004 from http://www.wedi.org/snip/public/articles/data_and_code_set_white_paper_011101.pdf
[32] CMS, 45 CFR 160. Retrieved from the internet on September 19, 2004 from http://www.cms.hhs.gov/hipaa/hipaa2/regulations/transactions/finalrule/txfin01.asp
[33] NCVHS. Retrieved from the internet on September 22, 2004, from http://www.ncvhs.hhs.gov
[34] Some leading users of ABC codes who have authorize release of their identities are described later in this report.
[35] Cleredi. Retrieved from the internet on September 22, 2004, from http://www.claredi.com/
[36] National Library of Medicine. Retrieved from the internet on September 22, 2004, http://medlineplus.nlm.nih.gov/
[37] The Accredited Standards Committee (ASC) X12 develops standards for cross-industry electronic exchange of business information
[38] HIPAA-DSMO. Retrieved from the internet on September 22, 2004, from http://www.hipaa-dsmo.org/crs/
[39] The National Committee on Vital and Health Statistics' (NCVHS') transcripts on ABC codes are available at www.ncvhs.hhs.gov. Please refer to the April 10th-11th, May 29th-30th, September 25th-26th and December 10th-11th hearings of 2002, as well as the January 29th-30th, March 25th-26th and May 20th-22nd hearings of 2003.
[40] "To conduct health services research, investigators need data from claim and encounter forms, specifically data coded using nationally accepted, standardized systems. National coding systems such as Common Procedure Terminology (sic) recognize some CAM interventions, but they are currently limited in scope and specificity. More recently, a coding system for CAM procedures, services, and products-ABC codes (sic)-has been developed and is being used in a number of settings. The National Committee for Vital and Health Statistics (sic) and DHHS should authorize a national coding system that supports standardized data on CAM for use in clinical and health services research. In addition, the coding system should support practitioners and insurers who cover CAM services in complying with the electronic claims requirements of the Health Insurance Portability and Accountability Act." White House Commission on Complementary and Alternative Medicine Final Report, March 2002.
[41] White House Commission on Complementary and Alternative Medicine, "Final Report, March 2002." Retrieved from the internet on September 22, 2004, from http://www.whccamp.hhs.gov/finalreport.html
[42] 2004 Congressional Record. Vol. 150. Retrieved from the internet on September 22, 2004, from http://www.gpoaccess.gov/crecord/index.html
[43] Institute of Medicine. Retrieved from the internet on September 22, 2004, from http://www.iom.edu/
[44] NCCAM. Retrieved from the internet on September 22, 2004, from http://www.nccam.nih.gov
[45] U.S. Department of Defense and Conemaugh Health Systems. Retrieved from the internet on September 22, 2004, from http://www.dod.gov and http://www.conemaugh.org/postpolio/approach.html
[46] The Consortium of Academic Health Centers for Integrative Medicine is supported by a grant from the Philanthropic Collaborative for Integrative Medicine. Its mission is to help transform medicine and healthcare through rigorous scientific studies, new models of clinical care, and innovative educational programs that integrate biomedicine, the complexity of human beings, the intrinsic nature of healing and the rich diversity of therapeutic systems. Twenty two academic health centers are current members of the Consortium. They are George Washington University, http://www.IntegrativeMedicineDC.com/, Oregon Health and Science University, http://www.ohsu.edu/women/, University of Calgary, http://www.ucalgary.ca/,University of Arizona, Program for Integrative Medicine, http://www.integrativemedicine.arizona.edu/, University of California, Los Angeles, Center for Integrative Medicine, http://www.mbcrc.med.ucla.edu/, University of California, San Francisco, Osher Center for Integrative Medicine, http://www.ucsf.edu/ocim, Columbia University, Richard and Hinda Rosenthal Center for Complementary & Alternative Medicine, http://cpmcnet.columbia.edu/dept/rehab/rehm0008.html, Duke University, Duke Center for

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Integrative Medicine,http://dukehealth.org/health_services/integrative_medicine.asp, Albert Einstein College of Medicine of Yeshiva University, Continuum Center for Health and Healing, http://www.healthandhealingny.org/, Georgetown University, Kaplan Clinic, http://www.georgetown.edu/schmed/cam, Harvard University, Osher Institute, http://www.osher.hms.harvard.edu/, University of Hawaii at Manoa, Program in Integrative Medicine, http://www.uhm.hawaii.edu/, Thomas Jefferson University, Center for Integrative Medicine, http://www.jeffersonhospital.org/cim, University of Maryland, Center for Integrative Medicine, http://www.compmed.umm.edu/, University of Massachusetts, Center for Mindfulness, http://www.umassmed.edu/cfm/, University of Michigan, Complementary & Alternative Research Center, http://www.med.umich.edu/camrc, University of Minnesota, Center for Spirituality and Healing, http://www.csh.umn.edu/, University of Medicine and Dentistry of New Jersey, Institute for Complementary & Alternative Medicine, http://www.umdnj.edu/icam, University of Pennsylvania, Office of Complementary Therapies, http://www.med.upenn.edu/progdev/compmed/steering.html, University of Pittsburgh, Center for Complementary Medicine, http://www.upmc.com/, University of Texas Medical Branch, UTMB Integrative Health Care, http://cam.utmb.edu/default.asp, University of Washington, Department of Family Medicine, http://www.fammed.washington.edu/predoctoral/cam. Source: http://www.bravewell.org/stratinit/consortium.asp

[47] ANA. Retrieved from the internet on September 22, 2004, from http://www.ana.org/

[48] NACNS. Retrieved from the internet on September 22, 2004, from http://www.nacns.org/special/

[49] The HHS Secretary may authorize exceptions in accordance with the Code of Federal Regulations, Title 45-Public Welfare, Volume 1, Subtitle A-Department of Health and Human Services, Part 162-Administrative Requirements, Subpart I-General Provisions for Transactions, Section 162.940-Exceptions from standards to permit testing of proposed modifications.

[50] Alternative Link in a New Mexico company that collaborates with the Foundation for IHC in developing ABC terminology and codes for IHC. IHC is care drawn from the best practices of conventional, complementary and alternative medicine.

[51] CMS reported that NCVHS findings believed that Alternative Link's financial interest in a favorable study outcome would lead to faulty research design, implementation and analysis.

[52] New and overlapping codes are now being developed by both the AMA and CMS.

[53] Alternative Link is unaware of efforts within CMS to secure or conduct cost-benefit studies of any individual HIPAA standard with the level of rigor established for the evaluation of ABC codes.

[54] Since the CMS guidelines for the cost-benefit evaluation of ABC codes could have made the cost-benefit evaluation untenable, Alternative Link followed the precedents established by CMS, WEDI and RAND. Alternative Link believes the cost-benefit of the code set are evident from 1) the gaps in HIPAA code sets and NHII standards, 2) the EDI-related functionality offered by ABC codes, 3) their growing use across the industry, and 4) the known cost-benefits of EDI. If further study is desired by HHS, Alternative Link would consider a deeper exploration of the cost-benefit of ABC codes supported by grants, administrative oversight and scientific guidance from one or more of the HHS agencies that could utilize data from the study itself to advance public health.

[55] 1) Reducing major threats to the health and well-being of Americans, including behavioral and other factors, sexually transmitted diseases and unintended pregnancies, missed immunizations, substance abuse (including tobacco use), and injuries and violence. 2) Enhancing the ability of the nation's health care system to effectively respond to bioterrorism and other public health challenges by building the capacity of the health care system to respond to public health threats in a more timely and effective manner, especially bioterrorism threats; and by improving the safety of food, drugs, biological products, and medical devices. 3) Increasing the percentage of the nation's children and adults who have access to health care services and expanding consumer choice by creating new, affordable health insurance options; strengthening and expanding the healthcare safety net; strengthening and improving Medicare; eliminate racial and ethnic health disparities; expanding access to health care services for targeted populations with special health care needs; and increasing access to health services for American Indians and Alaska Natives. 4) Enhancing the capacity and productivity of the nation's health science research enterprise by advancing the understanding of basic biomedical and behavioral science and how to prevent, diagnose, and treat disease and disability; accelerating private sector development of new drugs, biologic therapies, and medical technology; strengthening and diversifying the pool of qualified health and behavioral science researchers; improving the coordination, communication, and application of health research results; and strengthening the mechanisms for ensuring the protection of human subjects and the integrity of the research process. 5) Improving the quality of healthcare services by reduce medical errors; increasing

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the appropriate use of effective healthcare services by medical providers; increasing consumer and patient use of healthcare quality information; improving consumer and patient protections; and accelerating the development and use of an electronic health information infrastructure. 6) Improving the economic and social well-being of individuals, families, and communities, especially those most in need by increasing the proportion of low-income individuals and families, including those receiving welfare, who improve their economic condition; increasing the proportion of older Americans who stay active and healthy; increasing the independence and quality of life of persons with disabilities, including those with long-term care needs; improving the economic and social development of distressed communities; and expanding community and faith-based partnerships. 7) Improving the stability and healthy development of the nation's children and youth by promoting family formation and healthy marriages; improving the development and learning readiness of preschool children; increasing the involvement and financial support of non-custodial parents in the lives of their children; and increasing the percentage of children and youth living in a permanent, safe environment. 8) Achieving excellence in management practices by create a unified HHS committed to functioning as one Department; improving the strategic management of human capital; enhancing the efficiency and effectiveness of competitive sourcing; improving financial management; enhancing the use of information technology in service delivery and record keeping; achieving integration of budget and performance information; and reducing regulatory burden on providers and consumers of HHS services.

[56] Karen Trudel of the CMS Office of HIPAA Standards noted in 2003 that the NCVHS might view a cost-benefit analysis by Alternative Link with skepticism since Alternative Link has proprietary interest in ABC codes and would be financially enriched by the designation of ABC codes as a HIPAA standard.

[57] Alternative Link views the resulting evidence as sufficient to warrant immediate naming of the code set as a Level IV subset of HCPCS that is necessary for proper maintenance of HCPCS.

On the basis of the demonstrated cost-benefit of ABC codes in HIPAA transactions and other applications, Alternative Link believes considerable benefits—including prevention of human suffering and prevention of lost lives—will accrue to the nation as a whole, health industry businesses and the American public with early naming of ABC codes as part of the HIPAA code sets. As noted above, ABC codes support desirable endpoints beyond those addressed by HIPAA. For example, the codes not only support administrative simplification through standardized transactions and code sets, but also support the consumer-centric and interoperative national health information infrastructure (NHII) needed to ensure Americans gain access to the right care at the right place and time, at a rational cost.

[58] Barnes PM, Powell-Griner E, McFann K, Nahin RL. Complementary and alternative medicine use among adults: United States, 2002. Advance data from vital and health statistics; no 343. Hyattsville, Maryland: National Center for Health Statistics. 2004.

[59] Martin Libicki, Irene Brahmakulam. The Costs and Benefits of Moving to the ICD-10 Code Sets. RAND Corporation. Santa Monica, CA. 2004.

[60] Jennifer Hicks, “The Potential of Claims Data to Support the Measurement of Health Care Quality,” Dissertation for the RAND Graduate School, March 2003.

[61] CMS, “Impact Analysis,” Retrieved from the internet on September 17, 2004 from http://www.cms.hhs.gov/hipaa/hipaa2/regulations/identifiers/providerNPRM/npi10.asp

[62] “Claims Payment Carried Activity Directory.” Retrieved from the internet on September 15, 2004 from http://www.cms.hhs.gov/contractors/ABC/claims.pdf

[63] June Gibbs Brown, Inspector General, Memorandum to Bruce C. Vladeck,, Administrator, Health Care Financings Administration, titled, “Review of Medicare Providers and Electronic Claims Processing (A-05-94-00039),” May 31, 1996.

[64] DM Eisenberg, RB Davis, SL Ettner, S Appel, S Wilkey, M Van Rompay, RC Kessler, Center for Alternative Medicine Research and Education, Department of Medicine, Beth Israel Deaconess Medical Center, Boston, “Trends in Alternative Medicine Use in the United States: 1990-1997:Results of a Follow-Up National Survey,” JAMA, November 11, 1998; 280 (18): 1569-75.

[65] DM Eisenberg, RC Kessler, Cindy Foster, Frances E. Norlock, David R. Calkins, and Thomas L. Delbanco, “Unconventional Medicine in the United States: Prevalence, Costs, and Patterns of Use,” New England Journal of Medicine, Volume 328:246-252, January 28, 1993, No. 4.

[66] Richard K. Miller & Associates. *Healthcare Business Market Research Handbook.* January 2004.

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[67] Alternative Link is supplementing data from these sources with data compiled independently, through NHII stakeholder groups, HIPAA transaction and code set experts, and the Company's ABC code set registrants and petitioners.
[68] In this report, Alternative Link views RAND's cost-benefit study for ICD-10-PCS as a starting point for evaluating the implications of the data from demonstration sites
[69] Where possible, Alternative Link secured and analyzed such "surrogate" data in support of this report. Some of this information is protected under non-disclosure agreements between Alternative Link and the demonstration site. Nonetheless, upon CMS request, Alternative Link will coordinate agreements between CMS and these demonstration sites to facilitate uncloaking of demonstration site identities, to the degree this does not cause the confidential and proprietary information of Alternative Link or its demonstration sites to be releasable under the Freedom of Information Act.
[70] Raw data is protected under non-disclosure agreements between Alternative Link and each demonstration site. Nonetheless, upon CMS request, Alternative Link will coordinate agreements between CMS and targeted demonstration sites to facilitate uncloaking of demonstration site identities, to the degree this does not cause the confidential and proprietary information of Alternative Link or its demonstration sites to be releasable under the Freedom of Information Act.
[71] Edmund X. DeJesus, "Claims Processing Speeds Up," Healthcare Informatics Online, June 2000. Retrieved from the internet on September 19, 2004 from http://www.healthcare-informatics.com/issues/2000/06_00/dejesus.htm
[72] CMS. *Medicare Program; Procedures for Coding and Payment Determinations for Clinical Laboratory Tests and for Durable Medical Equipment.* Retrieved from the internet on September 14, 2004 from http://www.cms.hhs.gov/medicare/hcpcs/codpayproc.asp
[73] Synthia Laura Molina, CEO, Alternative Link. Analysis of September 30, 2004.
[74] Edmund X. DeJesus, "Claims Processing Speeds Up," Healthcare Informatics Online, June 2000. Retrieved from the internet on September 19, 2004 from http://www.healthcare-informatics.com/issues/2000/06_00/dejesus.htm
[75] Edmund X. DeJesus, "Claims Processing Speeds Up," Healthcare Informatics Online, June 2000. Retrieved from the internet on September 19, 2004 from http://www.healthcare-informatics.com/issues/2000/06_00/dejesus.htm
[76] Edmund X. DeJesus, "Claims Processing Speeds Up," Healthcare Informatics Online, June 2000. Retrieved from the internet on September 19, 2004 from http://www.healthcare-informatics.com/issues/2000/06_00/dejesus.htm
[77] CMS, "Impact Analysis," Retrieved from the internet on September 17, 2004 from http://www.cms.hhs.gov/hipaa/hipaa2/regulations/identifiers/providerNPRM/npi10.asp
[78] Data submitted by NaviMedix and American Healthcare Alliance suggested savings of $4 to $22 for conversion of a paper claims to EDI.
[79] Martin Libicki, Irene Brahmakulam. The Costs and Benefits of Moving to the ICD-10 Code Sets. RAND Corporation. Santa Monica, CA. 2004.
[80] These numbers were derived from the following sources: 802,411 MD: (Source: Pinnacle, "Physician Statistics Summary"); 50,776 DOs (Source: Pinnacle, "Physician Statistics Summary") 92,460 DDS/DMDs (Source: U.S. Department of Labor, 2002) 6,185,020 Health Practitioners (Source: U.S. Department of Labor, 2002).
[81] These numbers were derived from the following sources: 802,411 MD: (Source: Pinnacle, "Physician Statistics Summary"); 50,776 DOs (Source: Pinnacle, "Physician Statistics Summary") 92,460 DDS/DMDs (Source: U.S. Department of Labor, 2002) 6,185,020 Health Practitioners (Source: U.S. Department of Labor, 2002).
[82] These numbers were derived from the following sources: 802,411 MD: (Source: Pinnacle, "Physician Statistics Summary"); 50,776 DOs (Source: Pinnacle, "Physician Statistics Summary") 92,460 DDS/DMDs (Source: U.S. Department of Labor, 2002) 6,185,020 Health Practitioners (Source: U.S. Department of Labor, 2002).
[83] In contrast to the numbers available through the Department of Labor, American Medical Information, Inc., offers lists of 692,494 physicians (active and retired, on record with the AMA), 40,068 DOs, 157,228 dentists and 3.25 million nurses. These numbers suggest MDs, DOs and dentists represent 13.3% of all health practitioners.
[84] Calculation: 6,185,020 (Total Caregivers) - 802,411 (MDs) - 50,776 (DOs) - 92,460 (DDSs/DMDs) = 5,239,373
[85]Sandra McCarver and Liza Moran on behalf of WEDI, "Data and Code Set Compliance: A White-Paper Describing the Business Issues and Recommended Short and Long Term Solutions Associated With Data and Code Set Compliance," Draft, January 11, 2001, p. 4, Retrieved from the internet on September 19, 2004 from http://www.wedi.org/snip/public/articles/data_and_code_set_white_paper_011101.pdf
[86] Emphasis added by Alternative Link.

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[87] Source: American Medical Association, 2004.
[88] Source: American Medical Association, 2004.
[89] "Relative Values for Integrative Healthcare Using ABC Codes," Relative Value Studies, Inc., 2004, p. 210.
[90] CMS, "Impact Analysis," Retrieved from the internet on September 17, 2004 from http://www.cms.hhs.gov/hipaa/hipaa2/regulations/identifiers/providerNPRM/npi10.asp
[91] CMS, "Impact Analysis," Retrieved from the internet on September 17, 2004 from http://www.cms.hhs.gov/hipaa/hipaa2/regulations/identifiers/providerNPRM/npi10.asp
[92] CMS, "Impact Analysis," Retrieved from the internet on September 17, 2004 from http://www.cms.hhs.gov/hipaa/hipaa2/regulations/identifiers/providerNPRM/npi10.asp
[93] Martin Libicki, Irene Brahmakulam. The Costs and Benefits of Moving to the ICD-10 Code Sets. RAND Corporation. Santa Monica, CA. 2004, pp. xiii-xv.
[94] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, "2002 National Occupational Employment and Wage Estimates: Healthcare Practitioner and Technical Occupations." Retrieved from the internet on September 15, 2004 from http://stats/bls.gov/oes/2002/oes_29He.htm.
[95] Anecdotal reports compiled by Synthia Laura Molina of Alternative Link by September 20, 2004.
[96] U.S. Department of Labor, Bureau of Labor Statistics, Employment Projections, "Fastest Growing Occupations, 2002-2012." Retreived from the internet on September 15, 2004 from http://www.bls.gov/emp/emptab3.htm
[97] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, "2002 National Occupational Employment and Wage Estimates: Healthcare Practitioner and Technical Occupations." Retrieved from the internet on September 15, 2004 from http://stats/bls.gov/oes/2002/oes_29He.htm
[98] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, "2002 National Occupational Employment and Wage Estimates: Healthcare Practitioner and Technical Occupations." Retrieved from the internet on September 15, 2004 http://stats/bls.gov/oes/2002/oes_29He.htm
[99] The American Nurses Association recognizes ABC codes and represents the nation's 2.7 million Registered Nurses through its constituent member state nurses associations. Refer to the ANA's 9/17/01 letter of support for ABC codes as a HIPAA code set.
[100] 6,185,020 health practitioners – 853,187 MDs & DOs – 2,700,000 nurses (ANA) – 300,000 CAM practitioners = 2,239,373. If the population of nurses is derived from the Bureau of Labor Statistics (2,239,530), then the number of unspecified practitioners is 2,699,843.
[101] Wendy Abdo, Michael P. Broxterman, "Physician Statistics Summary: Review of the AMA's Findings on Physician Characteristics and Distributions," Pinnacle Health Group. Retrieved from the internet on September 15, 2004 http://www.phg.com/articlepf_a056
[102] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, "2002 National Occupational Employment and Wage Estimates: Healthcare Practitioner and Technical Occupations." Retrieved from the internet on September 15, 2004 http://stats/bls.gov/oes/2002/oes_29He.htm
[103] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, "2002 National Occupational Employment and Wage Estimates: Healthcare Practitioner and Technical Occupations." Retrieved from the internet on September 15, 2004 http://stats/bls.gov/oes/2002/oes_29He.htm
[104] The American Nurses Association recognizes ABC codes and represents the nation's 2.7 million Registered Nurses through its constituent member state nurses associations. Refer to the ANA's 9/17/01 letter of support for ABC codes as a HIPAA code set.
[105] Wendy Abdo, Michael P. Broxterman, "Physician Statistics Summary: Review of the AMA's Findings on Physician Characteristics and Distributions," Pinnacle Health Group. Retrieved from the Internet on September 15, 2004 http://www.phg.com/articlepf_a056 as of September 15, 2004.
[106] Refer to Alternative Link file name "DemoReportQuantCalc."
[107] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, "2002 National Occupational Employment and Wage Estimates: Healthcare Practitioner and Technical Occupations." http://stats/bls.gov/oes/2002/oes_29He.htm as of September 15, 2004.
[108] The American Nurses Association recognizes ABC codes and represents the nation's 2.7 million Registered Nurses through its constituent member state nurses associations. Refer to the ANA's 9/17/01 letter of support for ABC codes as a HIPAA code set.

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[109] Wendy Abdo, Michael P. Broxterman, "Physician Statistics Summary: Review of the AMA's Findings on Physician Characteristics and Distributions," Pinnacle Health Group. http://www.phg.com/articlepf_a056 as of September 15, 2004.
[110] Refer to Alternative Link file name "DemoReportQuantCalc."
[111] Refer to Alternative Link file name "DemoReportQuantCalc."
[112] Refer to Alternative Link file name "DemoReportQuantCalc."
[113] CMS, "Impact Analysis," Retrieved from the internet on September 17, 2004 from http://www.cms.hhs.gov/hipaa/hipaa2/regulations/identifiers/providerNPRM/npi10.asp
[114] No further cost-savings figures were found on the CMS web site or through other sources, so this report uses the figure of $1.5 billion in annual savings (adjusted to 2002) to institutional and MDs practitioners through deployment of the HIPAA code sets and other administrative simplification provisions.
[115] Calculated below.
[116] Calculated below.
[117] Calculated below.
[118] Calculated below.
[119] Calculated below.
[120] Demonstration sites for loading of ABC codes into software applications and information systems included (but were not limited to) the following: ClaimEDIx, Q4 2003; Fortis Health, June 1998; Integrihealth LLC, June 1998; Lytec, February 2003; Medical Professional Systems, Q2 2003; MPLMC June 1998; Optimum Health Services, Inc, June 1998.
[121] Martin Libicki, Irene Brahmakulam. The Costs and Benefits of Moving to the ICD-10 Code Sets. RAND Corporation. Santa Monica, CA. 2004. pp. 8-10.
[122] Refer to Alternative Link file name "DemoReportQuantCalc."
[123] This figure was derived from the CMS Impact Analysis, Table 1, and included large and small commercials, BCBS plans, TPAs, HMOs and PPOs.
[124] Alternative Link anticipates that each HCIT or claims management company will need to budget the equivalent of $10 for each of 10,000 customers.
[125] None of the demonstration sites reported any difficulty loading ABC codes into their systems. Source: Conversation with Melinna Giannini, Board Chair and Founder, September 2004.
[126] According to Betty Haley, Client Services Director, Alternative Link, loading the ABC code set into the Lytec system at the Medicare Advantage program's PPO took less than one hour of time for one technical sales professional. According to Brian Wham, CTO, Alternative Link, the loading of the ABC code set from a web service would take less than a day for a sophisticated health plan or HCIT company and 2 days for a novice organization. If IT SMEs were hired at $125/hour, the cost of deployment would be $2,000. This is less than 50% of the cost assumed for health plans and less than 25% of the cost assumed for HCIT companies.
[127] Martin Libicki, Irene Brahmakulam. The Costs and Benefits of Moving to the ICD-10 Code Sets. RAND Corporation. Santa Monica, CA. 2004., pp. 8-10.
[128] Refer to Alternative Link file name "DemoReportQuantCalc."
[129] This figure was derived from the CMS Impact Analysis, Table 1, and included large and small commercials, BCBS plans, TPAs, HMOs and PPOs.
[130] Numbers do not total due to rounding.
[131] This analysis assumes that guidance on incremental work of a similar nature to work already done is generally simpler to deliver and receive than guidance on work of a new nature.
[132] Martin Libicki, Irene Brahmakulam. The Costs and Benefits of Moving to the ICD-10 Code Sets. RAND Corporation. Santa Monica, CA. 2004., *Background Materials*, pp. 53-56 for an explanation of the relationship between mapping and the cost of transitioning from one code set to another.
[133] Martin Libicki, Irene Brahmakulam. *The Costs and Benefits of Moving to the ICD-10 Code Sets.* RAND Corporation. Santa Monica, CA. 2004.
[134] Martin Libicki, Irene Brahmakulam. The Costs and Benefits of Moving to the ICD-10 Code Sets. RAND Corporation. Santa Monica, CA. 2004, pp. 8-10.
[135] Refer to Alternative Link file name "DemoReportQuantCalc."
[136] 77% of Bridges in Medicine's IHCPs lacked coding knowledge before training.

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[137] Libicki and Brahmakulam, "Costs and Benefits…" (Rand, March 2004 Martin Libicki, Irene Brahmakulam. The Costs and Benefits of Moving to the ICD-10 Code Sets. RAND Corporation. Santa Monica, CA. 2004, pp. 8-10.
[138] Refer to Alternative Link file name "DemoReportQuantCalc."
[139] This figure was derived from the CMS Impact Analysis, Table 1, and included large and small commercials, BCBS plans, TPAs, HMOs and PPOs.
[140] Alternative Link anticipates that each HCIT or claims management company will need to budget the equivalent of $10 for each of 10,000 customers.
[141] Bridges in Medicine began using ABC codes in late 1999, before the HIPAA exception was granted. A new management team joined the PPO and the PPO was restructured at the time of the 45 CFR 162.940 authorization, so the codes were redeployed under the new management team to quantify deployment costs and document training costs.
[142] Refer to Alternative Link file name "DemoReportQuantCalc." Raw data was submitted by Jeffrey Sollins, MD, in September 2004 and the cost-benefit table was constructed by Betty Haley, Client Services Director, Alternative Link, the same month.
[143] Bridges in Medicine began using ABC codes in late 1999, before the HIPAA exception was granted. A new management team joined the PPO and the PPO was restructured at the time of the 45 CFR 162.940 authorization, so the codes were redeployed under the new management team to quantify deployment costs and document training costs.
[144] Refer to Alternative Link file name "DemoReportQuantCalc."
[145] A list of practitioners who received guidance and tools from Alternative Link to support EDI and HIPAA related initiatives can be made available under the confidentiality agreement between Alternative Link and CMS and with written permission or additional agreements with the practitioners.
[146] The SOAP note format organizes patient care information and, ultimately, supports practitioners in securing payment for unusual insurance claims. The acronym "SOAP" stands for S – Subjective, O – Objective, A – Assessment and P – Plan. The Subjective section contains information obtained from the patient and includes the patient's description of his/her complaints (e.g., "headache, cough, severe lower abdominal pain"). The Objective section includes the patient's vital signs, physical exam results (including mental status, if applicable), lab data, procedures with results, and other objective data. The Assessment section includes a review of the patient's data and the health practitioner's conclusions. The Plan section includes actions to be taken to support the patient's wellbeing.
[147] Many HCIT applications and systems lack data fields for legal scope of practice and training standards for IHC practitioners. Many of these applications and systems also lack turnkey rules engines that could apply these data to make automated determinations of the legality of related interventions. Development of HCIT application and system functionality to make use of these data elements in automated claims adjudication could involve conversions and upgrades and could be expected to add to start-up costs. These two data elements and the automated adjudication functionality associated with ABC codes are not proposed as part of the standard. However, they these data are as relevant to the cost-benefit of ABC codes in HIPAA transactions as today's claims adjudication systems and their rules engines are to the cost-benefit of other code sets, i.e., central. Alternative Link anticipates the cost of these upgrades will be borne by application and system developers as part of their competitive strategies. A precedent for addressing these costs as part of a code set cost-benefit analysis was established in the RAND cost-benefit analysis for ICD-10-CM and ICD-10-PCS. It anticipated a $50 million to $200 million cost associated with system changes for providers (predominantly for hospitals), $50 million to $125 million for software changes by application developers, and $100 to $250 million for payors, with CMS estimated separately at $25 million to $125 million, with no calculation for healthcare clearinghouses.
[148] Mitchell Medical licensed the HealthIntel Database in 2001 to support automated claims adjudication for automotive injury claims. The HealthIntel Database included the ABC codes, practitioner identifiers used as code modifiers, relative value units, legal scope of practice information (Yes/No logic), and training standards for allied health, nursing CAM and integrative practices and practitioners. Mitchell applications are described at Retrieved from the internet on September 17, 2004 from http://www.mitchell.com/mitch/solutions/medical.asp
[149] A list of organizations that received guidance and tools from Alternative Link to support automated adjudication or related initiatives can be made available under the confidentiality agreement between Alternative Link and CMS and with written permission or additional agreements with the organizations.
[150] They are therefore addressed with the ABC codes in both the qualitative and quantitative evaluation sections of this report.

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[151] The providers, health plans and healthcare clearinghouses that are the focus of this cost-benefit evaluation all reported creating costly workarounds to compensate for the lack of completeness, accuracy and precision in the HIPAA code sets. For example, a national health plan has programmed its claims adjudication software to kick out claims from IHCPs types for NEC, NOC and potentially fraudulent coding so these claims can be reviewed manually. This health plan's ABC code set deployment initiatives center on the ability of the codes to allow these claims to be automatically adjudicated and to severely curtail the need for costly manual reviews of these claims.
[152] Lawrence J. Blincoe, Angela G. Seay, M.Sc., Eduard Zaloshnja, Ph.D, Ted R. Miller, Ph.D., Eduardo O. Romano, Ph.D, Stephen Luchter, Rebecca S. Spicer, Ph.D. *The Economic Impact of Motor Vehicle Crashes 2002.* U.S. Department of Transportation - National Highway and Traffic Safety Administration. Washington, D.C. 2002. Report No. DOT HS 809 446.
[153] Patrick Johnston. *Workers' Compensation is Complicated and Confusing.* California Farm Bureau Federation. Sacramento, CA. 2003. Pg. 2.
[154] Refer to Alternative Link file name "DemoReportQuantCalc."
[155] Martin Libicki, Irene Brahmakulam. The Costs and Benefits of Moving to the ICD-10 Code Sets. RAND Corporation. Santa Monica, CA. 2004, *System Changes*, pp. 13-16.
[156] Health plans, healthcare clearinghouses and practitioners incurred negligible to substantial costs in loading ABC codes into software applications and adding related data elements and functionality.
The cost of loading ABC codes was negligible. ABC codes fit in the same data fields as HCPCS codes. The cost of loading related data elements and then programming applications to generate added functionality was substantial, but was not attributable to ABC codes for the reasons noted above. Identifying practitioners, updating relative value units, determining the legal and clinical appropriateness of care, and supporting credentialing are routine business processes that are more expensive to manage without ABC codes than with ABC codes.

Health plans and healthcare clearinghouses typically have their own healthcare information technology (HCIT) systems and maintain these with in-house or outsourced support. Practitioners tend to use off-the-shelf software applications developed and maintained by vendors. As anticipated by CMS in its "Impact Analysis," these entities determined how and when to load the data elements beyond ABC codes to minimize costs and maximize benefits. For example, health plans and clearinghouses informed Alternative Link of plans to load ABC codes and related data elements as part of a business process reengineering initiatives and software upgrades. Some practitioners chose to rely on outsourced billing agents and clearinghouses to deploy ABC codes and related functionalities.

Since ABC codes reduced the costs of the inefficient manual processes that were previously in place to deal with IHC claims, Alternative Link is attributing no incremental cost to system conversion and upgrades. These costs are the cost of doing business in an EDI and HIPAA compliant environment.
[157] Bridges in Medicine Medicare Advantage Fee Negotiating Spreadsheet. August, 2004.
[158] This number reflects the total number of practitioners able to bill by using ABC codes. Some of these practitioners may be institutionally employed and the savings would be accrued by the employing entity.
[159] ARC Consulting, as reported by Edmund X. DeJesus, "Claims Processing Speeds Up," Healthcare Informatics Online, June 2000. Retrieved from the internet on September 19, 2004 from http://www.healthcare-informatics.com/issues/2000/06_00/dejesus.htm
[160] ARC Consulting, as reported by Edmund X. DeJesus, "Claims Processing Speeds Up," Healthcare Informatics Online, June 2000. Retrieved from the internet on September 19, 2004 from http://www.healthcare-informatics.com/issues/2000/06_00/dejesus.htm
[161] The identity of the health plan may be made available upon execution of a non-disclosure agreement between CMS and the plan.
[162] The Henry J. Keiser Family Foundation. Retrieved from the internet on September 29, 2004 from http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=25474
[163] Data from 2003.
[164] Alternative Link's Legal Research Department, September 2004.
[165] The Henry J. Keiser Family Foundation. Retrieved from the internet on September 29, 2004 from http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=25474
[166] The United States Census Bureau. Retrieved from the internet on September 19, 2004 from http://quickfacts.census.gov/qfd/states/01000.html

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[167] Barnes P, Powell-Griner E, McFann K, Nahin R. *CDC Advance Data Report #343*. Complementary and Alternative Medicine Use Among Adults: United States, 2002. May 27, 2004.
[168] *David M. Eisenberg, MD; Roger B. Davis, ScD; Susan L. Ettner, PhD; Scott Appel, MS; Sonja Wilkey; Maria Van Rompay; Ronald C. Kessler, PhD "Trends in Alternative Medicine Use in the United States, 1990-1997: Results of a Follow-up Survey" JAMA, November 11, 1998-Vol 280, No. 18. American Medical Association. 1998.*
[169] *Landmark Healthcare. The Landmark Report II on Alternative Care. Sacramento, CA: Landmark Healthcare; 1999.*
[170] *David M. Eisenberg, MD; Roger B. Davis, ScD; Susan L. Ettner, PhD; Scott Appel, MS; Sonja Wilkey; Maria Van Rompay; Ronald C. Kessler, PhD "Trends in Alternative Medicine Use in the United States, 1990-1997: Results of a Follow-up Survey" JAMA, November 11, 1998-Vol 280, No. 18. American Medical Association. 1998.*
[171] *Landmark Healthcare. The Landmark Report II on Alternative Care. Sacramento, CA: Landmark Healthcare; 1999.*
[172] *Notice of Proposed Rule Making for the National Standard Health Care Provider Identifier* .Centers for Medicare & Medicaid Services. 1998. Retrieved from the internet on September 17, 2004 from http://www.cms.hhs.gov/hipaa/hipaa2/regulations/identifiers/providerNPRM/npi10.asp
[173] Refer to Alternative Link file name "DemoReportQuantCalc."
[174] Refer to Alternative Link file name "DemoReportQuantCalc."
[175] Daniel C. Cherkin, PhD; Richard A. Deyo, MD, MPH; Karen J. Sherman, PhD, MPH; L. Gary Hart, PhD; Janet H. Street, RN, MN, PNP; Andrea Hrbek; Roger B. Davis, ScD; Elaine Cramer, MD, MPH; Bruce Milliman, ND; Jennifer Booker, ND; Robert Mootz, DC, DABCO; James Barassi, DC; Janet R. Kahn, PhD, LMT; Ted J. Kaptchuk, OMD; & David M. Eisenberg, MD. "Characteristics of Visits to Licensed Acupuncturists, Chiropractors, Massage Therapists, & Naturopathic Physicians." The Journal of the American Board of Family Practice. November - December 2002 Vol. 15 No. 6, Pgs. 463-472. Retrieved from the internet on September 18, 2004 from http://www.jabfp.org/cgi/reprint/15/6/463?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext
[176] Official Directory: Chiropractic Licensure & Practice Statistics. Current Issue. Federation of Chiropractic Licensing Boards. 2003. Retrieved September 17, 2004 from http://www.fclb.org/directory/statistics.pdf
[177] Claims that require attachments are consider "complex" and were found by NaviMedix to cost $18 more to adjudicate than "simple" claims. Source: Scott Ryback, 2004.
[178] Refer to Alternative Link file name "DemoReportQuantCalc."
[179] Synthia Laura Molina, CEO, Alternative Link, 2004.
[180] Synthia Laura Molina, CEO, Alternative Link, 2004.
[181] "Electronic Claims Processing Confirms Claim Submission Electronically," Lytec. Retrieved from the internet on October 1, 2004 from http://www.2kmedicalbilling.net/eclaims/Lytec_benefits.html
[182] Betty Haley, Client Services Director, Alternative Link, October 5, 2004. (Betty Haley was formerly a benefits manager for Kinkos and Sutter Health, director of benefits for Kindercare and claims adjudicator for Aetna.)
[183] Synthia Laura Molina, CEO, Alternative Link, 2004.
[184] Synthia Laura Molina, CEO, Alternative Link, 2004.
[185] David C. Kibbe, MD, MBA, "What the HIPAA Transactions and Code Set Standards Will Mean for Your Practice." *Family Practice Management*. November/December (2001). Retrieved from the internet on September 17, 2004 from www.aafp.org/fpm/20011100/28what.html
[186] NaviMedix (www.navimedix.com) offers automated administrative and medical management transaction services, claim capture and claim editing functionality, expanded clinical services, integration services and deployment services to improve connectivity and efficiencies among health plans and providers. The Company delivers services to more than 70,000 physician and 500 hospital subscribers nationwide and works with Highmark Inc., Independence Blue Cross and Blue Cross of Northeastern Pennsylvania. In Pennsylvania alone, NaviMedix has helped 27,000 providers transact more than 50 different electronic processes using one, easy-to-use platform.
[187] Reported by Medicare Advantage program director, 2003.
[188] AHIP. Retrieved from the internet on September 30, 2004 from http://www.ahip.org/content/default.aspx?bc=39|343
[189] AHIP. Retrieved from the internet on September 30, 2004 from http://www.ahip.org/content/default.aspx?bc=39|343
[190] "Advanced Practice Nursing: A New Age in Health Care" Nursing Facts. Retrieved from the internet on September 19, 2004 from http://www.nursingworld.org/readroom/fsadvprc.htm,
[191] "Advanced Practice Nursing: A New Age in Health Care" Nursing Facts. etrieved from the internet on September 19, 2004 from http://www.nursingworld.org/readroom/fsadvprc.htm
[192] Melinna Giannini, Board Chair and Founder, September 2004.

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[193] CMS, Part B Physician/Supplier National Data: CY2001; "Top 200 Level I Current Procedural Terminology (HCPCS/CPT); Codes; Note: Codes Copyrighted by the American Medical Association
[194] Alternative Link, Legal Research Dept., 2004
[195] "Top 200 Level I Current Procedural Terminology" CMS, Part B, Physician/Supplier National Data CY2001.
[196] CMS, "Top CPT Codes Listed by Allowed Charges and Allowed Services," from www.cms.hhs.gov as of September 30, 2004.
[197] CMS, "Top CPT Codes Listed by Allowed Charges and Allowed Services," from www.cms.hhs.gov as of September 30, 2004.
[198] Refer to Alternative Link file name "DemoReportQuantCalc."
[199] Glossary indexes for all three of the following manuals were originally reviewed for nursing interventions (Most interventions in CPT and HCPCS were assumed to be for nurses.):

- ABC Coding Manual for Integrative Medicine: Sixth Edition Alternative Link, Inc. Albuquerque, NM. 2004.
- Current Procedural Terminology: CPT 2004. American Medical Association. Chicago, IL. 2004.
- HCPCS Millennium Edition: Health Care Procedure Coding System National Level II Medicare Codes. Practice Management information Corporation. Los Angeles, CA. 2003.

[200] This description is from CPT-4. Emphasis was added.
[201] NACNS, 2004.
[202] CMS, Part B Physician/Supplier National Data: CY2001; "Top 200 Level I Current Procedural Terminology (HCPCS/CPT); Codes; Note: Codes Copyrighted by the American Medical Association
[203] Alternative Link, Legal Research Dept., 2004
[204] Unsurveyed for 2004.
[205] CMS, "Top CPT Codes Listed by Allowed Charges and Allowed Services," from www.cms.hhs.gov as of September 30, 2004.
[206] Richard Furber, "Comparison of Data Capture for Back Pain Disorders: CPT Codes vs. ABC Codes," a Guideway™ deployed in support of a Fortune 200 employer's health plan, 2004.
[207] Estimate by Synthia Laura Molina, CEO of Alternative Link, on September 28, 2004.
[208] Many claims from these practitioners are billed under physicians, with physician administrative fees added, because of the lack of sufficiently precise coding in the HIPAA code sets.
[209] Refer to Alternative Link file name "DemoReportQuantCalc."
[210] Chiropractic billing patterns are assumed applicable to the direct bill population.
[211] The data elements are available through Alternative Link and others.
[212] Clinical efficacy data is available through organizations such as Natural Standard (www.naturalstandard.com). Cost-effectiveness data is more elusive and can be derived to some degree from peer-reviewed literature. ABC codes will make these data elements available to health plans through querying of their own data warehouses. Standard actuarial analyses will support determinations of medical necessity and economic and health outcomes.
[213] Washington, DC-based firm Muse & Associates, 1999.
[214] Prevalence of Selected Impairments. United States - 1971. National Center for Health Statistics, Hyattsville, Maryland - 1975, DHHS Publication No. (PHS)75-1526 (Series 10, No. 9) and 1981 DHHS Publication No. (PHS) 87-1587 (Series 10, No. 159)
[215] This data may be available to CMS, upon request, once a non-disclosure agreement is in place between CMS and MediMerge Health.
[216] Bridges in Medicine, 3924 Carlisle Blvd. NE,
Albuquerque, NM 87107. Tel.: 505-855-5545. Email: jeffreysollins@flash.net Web site: http://www.bridgesinmedicine.com/
[217] Bridges in Medicine supports Ardent Health Services/Lovelace Sandia Health System's Medicare Advantage program.
[218] This data may be available to CMS, upon request, once a non-disclosure agreement is in place between CMS and Bridges in Medicine.
[219] This data may be available to CMS, upon request, once a non-disclosure agreement is in place between CMS and Bridges in Medicine.

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[220] Presentation by Jeffrey S. Sollins MD, "Integrative Medicine Model," 2004 American Holistic Medical Association Conference, Albuquerque, NM, Retrieved from the internet on September 29, 2004 from http://www.holisticmedicine.org/pdfs/orderahma2004.pdf
[221] Personal Communication. Jeffrey Sollins, M.D., Bridges in Medicine.™ March, 2003.
[222] Kaiser Family Foundation and Health Research and Educational Trust report, September 2004.
[223] Refer to www.centerforpracticalreform.org as of Septmber 30, 2004.
[224] Sarah Rubenstein, "Growing acceptance: Workers are gaining limited access to acupuncture and chiropractic care (Employers offer more alternative medicine)," The Wall Street Journal, September 25, 2004.
[225] "Unconventional Claims," *Vegetarian Times*, October 27, 1995.
[226] *Traditional Chinese Medicine World*, Fall 1999, Vol. 1; Reprinted from *Physician's Financial News.*
[227] Cost per Case Analysis of Utah Industrial Back Injury Claims: Chiropractic Management vs. Medical Management for Diagnostically Equivalent Conditions. D.C. Tracts - 1989.
[228] Cost per Case Comparison of Back Injury Claims of Chiropractic versus medical Management for Conditions with Identical Diagnostic Codes. Jarvis KB, et al. Journal of Occupational Medicine - 1991;33:847-852.
[229] Sarah Rubenstein, "Growing acceptance: Workers are gaining limited access to acupuncture and chiropractic care (Employers offer more alternative medicine)," The Wall Street Journal, September 25, 2004.
[230] Miron Stano, Ph.D., Lead Researcher, Oakland University and Medstat Research.
[231] Weeks, J. "Is Alternative Medicine More Cost-Effective?" *Medical Economics*, March 20, 2000.
[232] Stano, M, Smith, M. "Chiropractic and medical cost of low back pain". *Medical Care* 1996; 34(3): 191-204
[233] Manga, P. Enhanced Chiropractic Coverage Under OHIP as a Means of Reducing Health Care Costs, Attaining Better Health Outcomes and Achieving Equitable Access to Health Services. Report to the Ontario Ministry of Health. 1998
[234] "Chiropractic More Cost-Effective Than Medicine Under Managed Care" Dynamic Chiropractic July 14, 2003, Volume 21, Issue 15. Retrieved from the internet on September 28, 2004 from www.chiroweb.com/archives/21/15/12.html
[235] Chiropractic comes of age at ACC-RAC 2003 Conference. *Dynamic Chiropractic* May 19, 2003. Retrieved from the internet on September 28, 2004 www.chiroweb.com/archives/21/11/01.html
[236] Nelson CF, Metz D, Legoretta A, LaBrot T. Effects of Inclusion of a Chiropractic Benefit on the Utilization of Health Care Resources in a Managed Health Care Plan. Unpublished.
[237] World Federation of Chiropractic 7th Biennial Congress in Orlando at the beginning of May 2003
[238] Average of 79% and 87% chiropractic coverage rates reported by Kaiser Family Foundation and Health Research and Educational Trust in September 2004.
[239] This and other compliance-related registrant communications are available upon request.
[240] This requirement was established in an approved exception from the HIPAA standard code sets, authorized January 16, 2003, by Secretary Tommy Thompson of the U.S. Department of Health and Human Services, under 45 CFR 162.940.
[241] Thus, the survey was administered only among those who already perceived enough value in securing rights to use ABC codes in HIPAA transactions to complete and submit the registration form. Survey respondents represented a population of entities predisposed to ABC codes (since they wanted continued access to the codes beyond the HIPAA transaction and code set compliance date).
[242] The database may be accessed and queried by CMS under a non-disclosure agreement established with Alternative Link. CMS queries may be run by CMS to confirm that ABC code registrants and trading partners are HIPAA compliant when they use ABC codes in HIPAA transactions since this was the stated rationale for the registration requirement.

[243] These rights were confirmed in an August 6, 2003, letter from Jared Adair, Director of the Centers for Medicare and Medicaid Services' Office of HIPAA Standards.

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[244] For example, one leading registrant, American Healthcare Alliance, had 4,025 hospital trading partners, 770 specialty hospital trading partners, 417,855 physician trading partners and 38,785 ancillary provider partners as of April 18, 2001. Another, Aetna, is one of the nation's largest health insurance companies, with $18 billion in sales. This company offers health care, dental, pharmacy, group life, disability, and long-term care insurance and employee benefits on behalf of small, mid-sized, and large multi-site national employers, as well as individuals and certain Medicare beneficiaries. As of January 2003, Aetna had more than 579,000 trading partners.
[245] Please refer to "An Overview of ABC code Design and Functionality," Alternative Link, © 2002.
[246] The need for greater code set expandability was noted by the National Committee on Vital and Health Statistics as early as 1993, as noted in the Committee's 1993 report to the Secretary of HHS on limitations of the current approach to administrative code sets.
[247] CMS, Retrieved from the internet on September 13, 2004 from http://www.cms.hhs.gov/medicare/hcpcs/codpayproc.asp
[248] CMS, Retrieved from the internet on September 13, 2004 from http://www.cms.hhs.gov/medicare/hcpcs/codpayproc.asp
[249] AMA, Retrieved from the internet on September 13, 2004 from http://www.ama-assn.org/ama/pub/category/2653.html
[250] For example, the CPT Editorial Panel requires 1) that the service/procedure receive approval from the Food and Drug Administration (FDA) for the specific use of devices or drugs; 2) that the service/procedure is performed across the country in multiple locations; 3) that many physicians or other health care professionals perform the service/procedure; and 4) that the clinical efficacy of the service/procedure has been well established and documented. By design, Category II/Performance Measurement and Category III/Emerging Technology codes are denied the relative value units (RVUs) that drive payment for services. Source: http://www.ama-assn.org/ama/pub/article/3866-3846.html
[251] Refer to http://cms.hhs.gov/medicare/hcpcs/codpayproc.asp as of September 13, 2004.
[252] Refer to http://cms.hhs.gov/medicare/hcpcs/codpayproc.asp as of September 13, 2004.
[253] Refer to http://cms.hhs.gov/medicare/hcpcs/default.asp as of September 13, 2004.
[254] Refer to http://www.cms.hhs.gov/medicare/hcpcs/2005alpha.pdf as of September 13, 2004.
[255] In developing new and revised Category I CPT codes the Advisory Committee and the Editorial Panel requires 1) that the service/procedure receive approval from the Food and Drug Administration (FDA) for the specific use of devices or drugs; 2) that the service/procedure is performed across the country in multiple locations; 3) that many physicians or other health care professionals perform the service/procedure; and 4) that the clinical efficacy of the service/procedure has been well established and documented. By design, Category II/Performance Measurement and Category III/Emerging Technology codes are denied the relative value units (RVUs) that drive payment for services. Source: http://www.ama-assn.org/ama/pub/article/3866-3846.html
[256] The lack of code precision in the physician-controlled or influenced HCPCS code sets blocks access to CAM and nursing interventions. It has the effect of a cartel in that it limits the volume of procedures available to the marketplace and artificially constrains the free market forces that would drive down prices and thereby help U.S. employers reduce their escalating employee benefit costs and improve profitability.
[257] Rules and Regulations, 50369-50370.
[258] For example, the codes are valuable in actuarial and outcomes studies, utilization and clinical practice management, managed care contracting and provider credentialing and a variety of other critical activities.
[259] Tommy G. Thompson and David J. Brailer, "The Decade of Health Information Technology: Delivering Consumer-centric and Information-rich Health Care," U.S. Department of Health and Human Services, Office of the National Coordinator for Health Information Technology, July 21, 2004.
[260] Under 45 CFR 162.940, ABC codes are considered "HIPAA-compliant" in EDI for code set *registrants* and their *trading partners*. *Registrants* are organizations and individuals that secured rights to use and evaluate ABC codes beyond the HIPAA transaction and code set compliance date of October 16, 2003, under a "demonstration program" authorized by the Secretary of HHS on January 16, 2003, in accordance with 45 CFR 162.940. For purposes of this report, *trading partners* are organizations and individuals that engage in EDI with code set registrants.
[261] For example, "CACAE" or moxabustion (the application of heat to acupoints, using moxa or other incandescent material, without causing pain or burning) is illegal if provided by a medical doctor in Hawaii, unless that physician is licensed as an acupuncturist (with 2175 hours of acupuncture training), but is legal if provided by a physician in Georgia, even with no training in oriental medicine.

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[262] Individuals with hypertension may have adverse reactions to conventional drugs but may be responsive to changes in diet or lifestyle. A Highmark Blue Cross Blue Shield study of the Dean Ornish program revealed dramatic economic and health outcomes improvements from this institutionalized CAM program. Source: https://www.highmarkbcbs.com/
[263] Pregnant women may require Cesarean deliveries and need acupuncture anesthesia because they cannot physically tolerate conventional anesthesia.
[264] Conventional medicine may not be an option for some individuals for socio-demographic, geographic and/or spiritual reasons. For example, Asian and Native Americans may seek their traditional remedies over conventional remedies because they are unfamiliar with the latter. New Mexicans may seek CAM services because the state is under served by conventional caregivers and the quality of conventional caregivers may be questionable. Christian Scientists may seek spiritual rather than drug or surgical interventions for religious reasons.
[265] If ABC codes continue to be excluded from EDI for non-registrants and non-trading partners, data on the care reflected by ABC codes will be largely lost to health policymakers. As a result, until ABC codes are named a subset of HCPCS or a freestanding HIPAA standard, more than 3 million IHC practitioners and more than 1.4 billion patient encounters will remain largely invisible to health policymakers.[265] The remaining gaps in the medical and dental codes, as well as in the NHII, will continue to compromise critical societal endpoints including individual and public health, business and industry efficiencies, and socioeconomic development. Alternative Link has testified and provided evidence that ongoing delays in the adoption of ABC codes could result in

1. no fewer than 1,000 American deaths every 20 days just from preventable hospitalizations and hospital-based errors and infections;
2. health policy decision making based on erroneous data;
3. increased vulnerability of the American people to public health risks (such as bio-terrorism and viral epidemics);
4. increased vulnerability of the American people to individual health risks (such as medical errors and adverse reactions);
5. widening of disparities in care delivered to geographically and medically underserved populations (e.g., impoverished, rural, ethnic and minority populations) and an increasingly limited ability to counter preventable conditions such as obesity, cardiovascular disease and diabetes, especially in Native American, Hispanic and African American populations;
6. administrative, financial and clinical inefficiencies in the healthcare system;
7. escalation of the medical price index (MPI);
8. inability to compare the economic and health outcomes of conventional, complementary and alternative approaches to care, and physician versus non-physician care, to identify the best practices available,
9. further escalation of health insurance premiums and greater difficulty for U.S. employers in sponsoring employee health benefits and meeting earnings projections;
10. greater budgetary pressure on, and needed benefit cutbacks in, Federal, state and military health plans;
11. restraint of trade and inequitable exposure to fraud and abuse charges for health practitioners other than MDS (with disproportionate exposure to protected populations, such as racial and ethnic minorities and females, who dominate certain allied and public health, nursing, CAM and integrative health professions);
12. empowerment of organizations and individuals that may gain financially from the proliferation of disease over those that may gain financially from prevention of illness and a greater orientation toward wellness;
13. a compromise of Congressional intent under HIPAA;
14. a substandard NHII; and
15. a slowdown in the U.S. economy.

[266] CMS, "Impact Analysis," Retrieved from the internet on September 17, 2004 from http://www.cms.hhs.gov/hipaa/hipaa2/regulations/identifiers/providerNPRM/npi10.asp
[267] Hearing; NCVHS Subcommittee on Standards and Security; May 30, 2002; Testimony of Michael Beebe. Source: http://www.ncvhs.hhs.gov/020530tr.htm
[268] "Crosswalk: ABC codes to HCPCS Level I and II," September 2002, Peggy Gregory, Stat Solutions, Inc., P.O. Box 15206, Clearwater, FL 33766-5206. Tel: 877-221-2125.
[269] These mission-critical business processes include health insurance benefit design, managed care and provider contracting, utilization and clinical practice management, claims processing, outcomes research and actuarial analyses.
[270] See "Comments on Proposed Rule, Health Insurance Reform Standards for Electronic Transactions (Refer to File Code HCFA-0149-P)," prepared by Alternative Link, 06/30/98.

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[271] Email; C. Kaye Riley to Melinna Giannini; "Re: ABC codes,"03/13/02.
[272] The modifier does not compromise the 5-character alpha string that proceeds it. Those 5-characters ensure one term in used to describe similar interventions delivered by multiple provider types. The modifier is *optional* and helps covered entities determine the appropriateness and legality of having a particular provider type deliver a particular intervention in a particular state.
[273] In 2004, NaviMedix reported a clean paper claim adjudication cost of $5 and $23 for a complex claim.
[274] Kenneth R. Pelletier, PhD, and John A. Astin, PhD, "Integration and Reimbursement of Complementary and Alternative Medicine by Managed Care and Insurance Providers: 2000 Update and Cohort Analysis," Alternative Therapies in Health and Medicine, Jan/Feb 2002, Vol. 8, No. 1, p. 37-43.
[275] PPO stands for preferred provider organization.
[276] Carve out plans transfer financial risk and responsibility for care to other covered entities, e.g., a major health insurer may carve out chiropractic benefits to a specialty insurer or preferred provider organization such as American Specialty Health Networks.
[277] Affinity plans provide members with discounts on non-covered services, e.g., 25% lower out of pocket costs for chiropractic visits made to participating providers.
[278] Office of Minority Health, Guadalupe Pacheco and co-workers, 2003.
[279] Carol Bickford, ANA, 2002. NHII Workgroup on Standards and Vocabularies, 2003. NHII Workgroups on Standards and Architecture, Measuring Progress, Population Health, Personal Health, 2004.
[280] Federal Register/Vol. 65, No. 160/Thursday, August 17, 2000/Rules and Regulations, 50369-50370.
[281] CPT codes do not accurately describe the practices of IHC practitioners. They do not provide information on the legality of IHC practices on a per intervention, per practitioner and per state basis.
[282] OPM Chief of Staff and Head of the Federal Employee Health Benefit, May 2004.
[283] A letter of intent from this health plan can be made available upon execution of a non-disclosure and non-compete agreement approved by the health plan.
[284] Aviacode's emailed letter of intent is available upon request.
[285] Founded in 1833, with annual revenues of more than $50 billion, McKesson ranks as the 20th largest industrial company in the United States. It delivers healthcare-related services and information technology solutions that help customers deliver high-quality healthcare by reducing costs, streamlining processes and improving the quality and safety of patient care. In its 170-year history, McKesson has grown to provide pharmaceutical and medical-surgical supply management across the spectrum of care; healthcare information technology for hospitals, homecare and payors; hospital and retail pharmacy automation; and services for manufacturers and payors designed to improve outcomes for patients.
[286] This uniformity and consistency should extend to standard HIPAA data element definitions and codes and their privacy and security requirements.
[287] Federal Register/Vol. 65, No. 160/Thursday, August 17, 2000/Rules and Regulations, 50369-50370.
[288] Retrieved from the internet on September 19, 2004 from http://www.hipaadvisory.com/regs/tcs_add/background.htm
[289] Federal Register/Vol. 65, No. 160/Thursday, August 17, 2000/Rules and Regulations, 50369-50370.
[290] David M. Eisenberg, MD; Roger B. Davis, ScD; Susan L. Ettner, PhD; Scott Appel, MS; Sonja Wilkey; Maria Van Rompay; Ronald C. Kessler, PhD "Trends in Alternative Medicine Use in the United States, 1990-1997: Results of a Follow-up Survey" JAMA, November 11, 1998-Vol 280, No. 18. American Medical Association. 1998.
[291] Barnes P, Powell-Griner E, McFann K, Nahin R. *CDC Advance Data Report #343*. Complementary and Alternative Medicine Use Among Adults: United States, 2002. May 27, 2004.
[292] "National Ambulatory Medical Care Survey," National Center for Health Statistics, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, 1998, 1999, 2000, 2001.
[293] More information on this initiative will be provided upon completion of a non-disclosure and non-compete agreement acceptable to Alternative Link and the national health plan.
[294] More information on this initiative will be provided upon completion of a non-disclosure and non-compete agreement acceptable to Alternative Link and the BC/BS plan.
[295] Federal Register/Vol. 65, No. 160/Thursday, August 17, 2000/Rules and Regulations, 50369-50370.
[296] The development process for ABC codes was described in the exception application under 45 CFR 162.940..
[297] Federal Register/Vol. 65, No. 160/Thursday, August 17, 2000/Rules and Regulations, 50369-50370.
[298] Refer to Betsy Humphreys, MLS, National Library of Medicine, for more information.

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[299] Retrieved from the internet on September 14, 2004 from http://www.apelon.com/ Apelon provides terminology solutions that enable healthcare organizations to develop structured, standard vocabularies that link to proprietary coding systems such as ICD, CPT, and SNOMED, as well as to public domain knowledge sources such as the National Library of Medicine's PubMed. Apelon's applications enable the creation of new vocabularies and the enhancement of existing ones, and the applications adapt to regional and institutional preferences. Apelon tools facilitate the efficient indexing and retrieval of related healthcare information. Apelon is making available a free, Web-based browser for national standard terminologies. Developed in support of the recently announced availability of SNOMED CT, the browser will contain the key national terminologies identified by HHS and the National Health Information Infrastructure (NHII) and Consolidated Health Informatics (CHI) initiatives.
[300] Apelon's Terminology Development Environment (TDE) for terminology authoring is an integrated suite of workstation tools and services to assist organizations in the creation and management of formally structured terminologies. TDE is used by the AMA to create CPT, and by SNOMED to create SNOMED-CT.
[301] Retrieved from the internet on September 14, 2004 from http://www.naturalstandard.com/
[302] More information on this initiative will be provided upon completion of a non-disclosure and non-compete agreement acceptable to Alternative Link and Natural Standard.
[303] Current on the internet as of September 14, 2004 http://shop.alternativelink.com/index.asp?PageAction=VIEWPROD&ProdID=11
[304] Distribution partners include FedEx Kinkos, ChiroCode Institute and others.
[305] Chirocode. Retrieved from the internet on September 14, 2004 from http://www.chirocode.com/deskbook.cfm
[306] Retrieved from the internet on September 14, 2004 from http://www.rvsdata.com/ps2.html
[307]Retrieved from the internet on September 14, 2004 from http://www.claredi.com/faq.php?faq_id=6&PHPSESSID=68aa9836f2d9192545b8d7cafd3426fe
[308] Information from this initiative is available upon completion of a non-disclosure and non-complete agreement acceptable to both Bridges in Medicine and Ardent Lovelace Sandia.
[309] Federal Register/Vol. 65, No. 160/Thursday, August 17, 2000/Rules and Regulations, 50369-50370.
[310] Federal Register/Vol. 65, No. 160/Thursday, August 17, 2000/Rules and Regulations, 50369-50370.
[311] Federal Register/Vol. 65, No. 160/Thursday, August 17, 2000/Rules and Regulations, 50369-50370.
[312] If a billing specialist or adjuster fails to do this, the healthcare provider and third party payor may be at risk of processing fraudulent claims that could result in substantial fines and, potentially, criminal indictment.
[313] Federal Register/Vol. 65, No. 160/Thursday, August 17, 2000/Rules and Regulations, 50369-50370.
[314] The 7-character PCS-format may require radical redesign of the NHII and health industry stakeholders' business processes, information systems, software applications, data fields and insurance forms.
[315] AMA/ASSN. Retrieved from the internet on September 30, 2004 from www.ama-assn.org
[316] CMS. Retrieved from the internet on September 30, 2004 from www.cms.hhs.gov
[317] American Standard Code for Information Interchange.
[318] A member of the AMA chairs the National Uniform Claim Committee. A member of the AMA also sits on the NUBC. A member of the American Hospital Association (a disease-based rather than health-based care model) chairs the National Uniform Billing Committee.
[319] A "captured agency" is a government entity—especially a regulatory agency—that is largely under the influence of the economic interest group that is most directly and massively affected by its decisions and policies. A captured agency shapes its regulations and policies primarily to benefit this special interest group at the expense of less organized and often less influential groups, rather than designs them in accordance with some broader or more inclusive conception of the public interest. Source: http://www.auburn.edu/~johnspm/gloss/index.html?http://www.auburn.edu/~johnspm/gloss/natural_monopoly.html
[320] This Act provides that "Every agency shall proceed with reasonable dispatch to conclude any matter presented to it except that due regard shall be had for the convenience and necessity of the parties or their representatives." Source: http://www.law.fsu.edu/library/admin/1947v.html
[321] The worst case scenario for coding in healthcare is roughly akin to having an American Food Association keeping international foods off the grocery store shelves by withholding UPCs for Italian, Chinese, Mexican and other non-domestic food products. In healthcare, however, biased coding could result in lost lives, lower quality care and inflated costs—not just reduced consumer choice.

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[322] The Company remains concerned about the civil rights of the predominantly female and, often, ethnic caregivers who are currently underserved by the HIPAA code sets, financially and politically disenfranchised from mainstream healthcare, and subject to greater risk of fraud and abuse charges in trying to fit their practices into ill fitting HCPCS codes.
[323] Note, for example, coding guidance offered in "ACA's Official Chiropractic Coding Solutions 2001," (ACA Press, 2001).
[324] A precedent for this was set in an Agreement between the American Dental Association (ADA) and the Centers for Medicare and Medicaid Services (CMS) to include Current Dental Terminology (CDT) in the Healthcare Common Procedure Coding System (HCPCS) Level II.
[325] Victoria Craig Bunce, JP Wieske. *Health Insurance Mandates in The United States - 2004*. Council for Affordable Health Insurance. Alexandria, VA. 2004. Retrieved from the internet on October 6, 2004 from http://www.cahi.org/cahi_contents/resources/pdf/Mandatepub2004Electronic.pdf
[326] Marsha Lillie-Blanton, Osula Evadne Rushing, Sonia Ruiz. *Key Facts: Race, Ethnicity & Medical Care*. The Henry J. Kaiser Family Foundation. Washington DC. June 2003. Retrieved from the internet on October 6, 2004 from http://www.kff.org/minorityhealth/6069-index.cfm

[327] Traditional medicine as described by the World Health Organization includes indigenous populations use of botanicals and other natural substance for healthcare.
[328] Retrieved from the internet on September 29, 2004 from http://www.ama-assn.org/ama/pub/article/2403-8065.html
[329] Retrieved from the internet on September 29, 2004 from http://www.pbs.org/healthcarecrisis/classroom_timeline.html
[330] CPT is an acronym for the American Medical Association's Current Procedural Terminology, a code set named a national standard under HIPAA in the August 17, 2000 Final Rule published in the Federal Register.
[331] Retrieved from the internet on September 29, 2004 from www.ama-assn.org and www.bls.gov/oco/print/ocos072.htm
[332] This figure was derived from 629 million reported visits to CAM practitioners in 1997 (Eisenberg/Harvard Study, 1998), and a compounded annual growth rate of 14.2%.
[333] This has been emphasized by expert panels from the National Committee on Vital and Health Statistics (NCVHS), the President's Information Technology Advisory Committee, the Institute of Medicine of the National Academies (IOM) and other influential organizations in the health industry.
[334] A list of white papers, conferences, trade publications and articles that have covered ABC codes is available, upon request, from Alternative Link.
[335] Retrieved from the internet on September 29, 2004 from http://nhii-03.s-3.net/welcome.htm
[336] Retrieved from the internet on September 29, 2004 from http://nhii-03.s-3.net/tracks.htm
[337] Retrieved from the internet on September 29, 2004 from http://nhii-03.s-3.net/materials.htm
[338] The National Health Care Influencers' Assembly, The World Health Care Congress, 'Background/Support for the Draft Resolution,'" The Center for Practical Health Reform, P.O. Box 330911, Atlantic Beach, Florida. 2004. Source: http://www.practicalhealthreform.org/crisis.html
[339] Retrieved from the internet on September 29, 2004 from http://www.pbs.org/healthcarecrisis/healthinsurance.html
[340] Retrieved from the internet on September 29, 2004 from http://www.practicalhealthreform.org/impact.html
[341] Retrieved from the internet on September 29, 2004 from http://www.ama-assn.org/ama/pub/article/2403-8065.html
[342] Retrieved from the internet on September 29, 2004 from http://www.pbs.org/healthcarecrisis/classroom_timeline.html
[343] Retrieved from the internet on September 29, 2004 from http://www.practicalhealthreform.org/impact.html
[344] Retrieved from the internet on September 29, 2004 from http://www.practicalhealthreform.org/impact.html
[345] Retrieved from the internet on September 29, 2004 from http://www.practicalhealthreform.org/impact.html
[346] Retrieved from the internet on September 29, 2004 from http://www.practicalhealthreform.org/impact.html
[347] Retrieved from the internet on September 29, 2004 from http://www.practicalhealthreform.org/impact.html
[348] Retrieved from the internet on September 29, 2004 from http://www.practicalhealthreform.org/impact.html
[349] Retrieved from the internet on September 29, 2004 from http://www.practicalhealthreform.org/impact.html
[350] Retrieved from the internet on September 29, 2004 from http://www.practicalhealthreform.org/impact.html
[351] This capability is described in U.S. Patent #5,915,241 and other U.S. and international patents pending.

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[352] This figure and its comparison to the number of conventional physician visits were derived from the Eisenberg/Harvard study on CAM, published in 1997, a 14.2% compounded annual growth rate estimated for this sector, and "National Ambulatory Medical Care Survey: 2000 Summary," Donald K. Cherry and David A. Woodwell, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, Advance Data from Vital and Health Statistics, Number 328, June 5, 2002, and the prior year's report (Number 322, July 17, 2001) by the same authors and Catharine W. Burt, Ed.D.
[353] Retrieved from the internet on September 29, 2004 from http://www.ama-assn.org/ama/pub/article/3866-3846.html
[354] Retrieved from the internet on September 29, 2004 from http://www.ama-assn.org/ama/pub/article/3866-3846.html
[355]Retrieved from the internet on September 29, 2004 from http://www.ada.org/prof/resources/topics/cdt/change_evaluation.asp
[356] Retrieved from the internet on September 29, 2004 from http://www.cms.hhs.gov/medicare/hcpcs/2005alpha.pdf
[357] NCVHS noted that both classification systems 1) lacked space for expansion, 2) had overlapping and duplicative codes, 3) had inconsistent and non-current use of terminology, 4) lacked codes for preventive services. It noted that ICD-9-CM (Volume 3) had insufficient specificity and detail and insufficient structure to capture new technology. It also noted that CPT-4 had a nonhierarchical structure, a physician service orientation rather than a multidisciplinary orientation, and poorly define, non-discrete coding categories with variable coding details.
[358] This has been emphasized by expert panels from the National Committee on Vital and Health Statistics (NCVHS), the President's Information Technology Advisory Committee, the Institute of Medicine of the National Academies (IOM) and other influential organizations in the health industry.
[359] A list of white papers, conferences, trade publications and articles that have covered ABC codes is available, upon request, from Alternative Link.
[360]Retrieved from the internet on September 29, 2004 from http://nhii-03.s-3.net/welcome.htm
[361] Retrieved from the internet on September 29, 2004 from http://nhii-03.s-3.net/tracks.htm
[362] Retrieved from the internet on September 29, 2004 from http://nhii-03.s-3.net/materials.htm
[363] Retrieved from the internet on September 29, 2004 from http://nhii-03.s-3.net/materials.htm
[364] Healthcare Common Procedure Coding System.
[365] Federal Register, Vol. 63, No. 88/Thursday, May 7, 1998/Proposed Rules, 25283.
[366] Please refer to Change Request Number 493 Detail, dated 9/20/01, under the section entitled, "Asking named code set developers for codes to support alternative medicine and nursing."
[367] Please refer to an email, dated 03/13/02 from C. Kaye Riley (HCFA/CMS) to Melinna Giannini (President of Alternative Link), with the subject line, "Re: ABC codes.
[368] CMS.
[369] Federal Register, Vol. 63, No. 88/Thursday, May 7, 1998/Proposed Rules, 25280.
[370] At the fall 2001 and winter 2002 meetings of the X12N committee, Alternative Link had reported to DSMO membership that Alternative Link had previously experienced difficulty in securing AMA collaboration and cooperation. These difficulties are noted in a summary entitled, "American Medical Association Licensing Agreement Issues Pertaining to ABC codes," dated 04/02/02. The document is available upon request.
[371] A copy of this and subsequent communications is available upon request.
[372] Federal Register, Vol. 63, No. 88/Thursday, May 7, 1998/Proposed Rules, 25281.
[373] Please refer to the Detail for Change Request Number 493, dated 9/20/01.
[374] Please refer to the Detail for Change Request Number 493, dated 9/20/01.
[375] Federal Register/Vol.63, No. 88/Thursday, May 7, 1998/Proposed Rules.
[376] Federal Register/Vol.63, No. 88/Thursday, May 7, 1998/Proposed Rules, 25274.
[377] See "Comments on Proposed Rule, Health Insurance Reform Standards for Electronic Transactions (Refer to File Code HCFA-0149-P)," prepared by Alternative Link, 06/30/98.
[378] See an email from C. Kaye Riley to Melinna Giannini, dated 03/13/02, with subject line, "Re: ABC codes." This document is available upon request.
[379] Federal Register/Vol.63, No. 88/Thursday, May 7, 1998/Proposed Rules, 25274.
[380] Federal Register/Vol.63, No. 88/Thursday, May 7, 1998/Proposed Rules, 25274.
[381] Federal Register/Vol.63, No. 88/Thursday, May 7, 1998/Proposed Rules, 25274.
[382] Federal Register/Vol.63, No. 88/Thursday, May 7, 1998/Proposed Rules, 25274.
[383] Federal Register/Vol.63, No. 88/Thursday, May 7, 1998/Proposed Rules, 25274.

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[384] Federal Register/Vol.63, No. 88/Thursday, May 7, 1998/Proposed Rules, 25274.
[385] Federal Register/Vol.63, No. 88/Thursday, May 7, 1998/Proposed Rules, 25274.
[386] The CAM and Nursing Coding Manual, (Delmar/Thomson Publishing, 2001), 69.
[387] Federal Register/Vol.63, No. 88/Thursday, May 7, 1998/Proposed Rules, 25274.
[388] Federal Register/Vol.63, No. 88/Thursday, May 7, 1998/Proposed Rules, 25274.
[389] Note, for example, coding guidance offered in "ACA's Official Chiropractic Coding Solutions 2001," (ACA Press, 2001).
[390] Note, for example, the lawsuit between the American Chiropractic Association and the American Medical Association, implying restraint of trade by the latter against the former.
[391] See http:/www.ama-assn.org/ama/pub/category/1855.html for the AMA's core purpose, core values, envisioned future, and key objectives and strategy. Also, note that articles published from the perspective of physician practitioners dominate the AMA's journal (JAMA).
[392] David Riley, MD, in correspondence dated January 3, 2002.
[393] Eisenberg, DM, Et al. "Trends in Alternative Medicine Use in the United States, 1990-1997." JAMA 1998: 280: 1569-1575.
[394] For example, Germany, Switzerland and the United Kingdom use diagnoses codes but have not yet fully implemented codes that identify all interventions in all sites of service.
[395] Retrieved from the internet on September 29 2004 from http://www.wrgh.org/
[396] Alternative Therapies in Health and Medicine, InnoVision Communications, Encinitas, California.
[397] Riley D, et al Homeopathy and Conventional Medicine: An Outcomes Study Comparing Effectiveness in a Primary Care Setting. JACM, Volume 7(2), 149-159.
[398] Alternative Link holds a patent on the use of 5-character codes with 2-character modifiers, legal information and relative value units to edit and scrub insurance claims for alternative medicine, nursing and other non-MD interventions.
[399] Retrieved from the internet on September 29, 2004 from http://www.ama-assn.org/ama/pub/category/3779.html.
[400] Retrieved from the internet on September 29, 2004 from http://www.ama-assn.org/ama/pub/category/1811.html
[401] Retrieved from the internet on September 29, 2004 from http://www.ama-assn.org/ama/pub/category/1854.html
[402] Retrieved from the internet on September 29, 2004 from http://www.ama-assn.org/ama/pub/category/1922.html
[403] Retrieved from the internet on September 29, 2004 from http://www.ama-assn.org
[404] D. Ted Lewers, MD.
[405] Please refer to http://qualityforum.org.
[406] Journal American Medical Association, Vol 284, July 26, 2000.
[407] Eisenberg DM et al. Trends in alternative medicine use in the United States, 1990-1997. JAMA 280, 1998 p.1569-1575
[408] .1(200,000)(8) + .1(200,000)(8) = 360,000.
[409] .1(200,000)(8) = 160,000.
[410] .1(200,000) = 20,000. 20,000/365=54.8.
[411] This assumes the AMA is able to develop 1/8 of the ABC codes per year and that 200,000 lives are lost per year due to hospital and physician errors, as well as known side effects of conventional treatments.
[412] .1(200,000)/365 = 54.8. 3100/54.8 = 56.6.
[413] Please refer to http://www.delmar.com/cam/ and http://www.rvsdata.com/ps2.html to learn more about ABC codes and related resources.
[414] Journal American Medical Association, Vol 284, July 26, 2000.
[415] Dun's Market Identifiers, D&B Business Information Report, December 8, 2003. Sales revision date January 4, 2004.
[416] Dun's Market Identifiers, D&B Business Information Report, October 24, 2003. Sales revision date January 4, 2004.
[417] A PowerPoint presentation on this Showcase Project is available upon request and reveals that ABC codes can enhance the efficiencies of business processes that are essential to protecting and enhancing market share and profitability in a consumer-driven health environment.
[418] Brochures from these talks are available upon request.

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[419] Dun's Market Identifiers, D&B Business Information Report, December 9, 2003. Sales revision date January 4, 2004.
[420] Hoover's Company Capsules, 2004.
[421] The Business Journal, Vol. 18, No. 40, p. 11, December 26, 2003. (ISSN: 08875588)
[422] Hoover's Company Capsules, 2004. Load date March 16, 2004.
[423] Dun's Market Identifiers, D&B Business Information Report, January 4, 2004.
[424] D&B Business Information Report, November 12, 2003. Sales revision date January 4, 2004.
[425] Hoover's Company Capsules, 2004.
[426] D&B Business Information Report, April 21, 2003. Sales revision date January 4, 2004.
[427] Hellman & Friedman LLC, a San Francisco-based private equity firm, acquired Mitchell from The Thomson Corporation in the Spring of 2000. Hellman & Friedman LLC was founded in 1984 and has raised and managed more than $4.8 billion of capital, which it has invested in over 40 companies.[427]
[428] Mitchell. Retrieved from the internet on September 13, 2004 from http://www.mitchell.com/mitch/solutions/medical.asp
[429] Refer to Scott Rybak, Vice President of Program Management, NaviMedix, c/o srybak@navimedix.com.

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